MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11815 — 11828

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY: Anne Arundel — MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): 24 Randall St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland — b. COUNTY: Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. STREET ADDRESS: 24 Randall St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: J. — Last: ANDRIE

4. DATE OF DEATH: Month: SEPT — Day: 5 — Year: 1967

5. SEX: male

6. COLOR OR RACE: caus.

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 29, 1879

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photo Engraver

10b. KIND OF BUSINESS OR INDUSTRY: Printing

11. BIRTHPLACE (County & State, or foreign country): Brooklyn, New York

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: — unknown

14. MOTHER'S MAIDEN NAME: — unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 0780-59-1116

17. INFORMANT Address: Mrs. Millicent B. Andrie - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral accident (Cerebral Hemorrhage.

DUE TO (b): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Immediate

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1, 19 67 to 9/5, 19 67 that (I) (we) last saw the deceased alive on 9/5, 19 67 and that death occurred at ... M. from the causes and on the date stated above.

22a. SIGNATURE: Albert L. Anderson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Albert L. Anderson, MD

22d. ADDRESS: 44 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: Sept. 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory

23d. LOCATION (City, town or county) (State): Washington D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Beverley E. Hopping

ADDRESS: Beverley E. Hopping

HOPPING FUNERAL HOME - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15 (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11816

CERTIFICATE OF DEATH

11829

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena, Maryland 02-1
d. STREET ADDRESS: Box 392 B Rt#4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: R. — Last: Baker
4. DATE OF DEATH: Month: 9 — Day: 14 — Year: 19 67
5. SEX: M
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/20/98
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Henry Baker
14. MOTHER'S MAIDEN NAME: Martha Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 217-07-8654
17. INFORMANT — Address: Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
443 X
IMMEDIATE CAUSE (a): Pulmonary Embolism; uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Arteriosclerotic Hypertensive cardio-vascular disease.
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/1, 1966, to 9/14-, 1967, that (I) (we) last saw the deceased alive on 9/14 19 67, and that death occurred at 7:00 A M, from causes and on the date stated above.

22a. SIGNATURE: O. Dorkan, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 9/14/67
22c. PHYSICIAN'S NAME (Type): C. Dorkan
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-17-67
23c. NAME OF CEMETERY OR CREMATORY: Mt Zion
23d. LOCATION (City or Town) (County) (State): Maytby, Pasadena RD

24. FUNERAL DIRECTOR — ADDRESS: Marshall Wagner 638 N. Gilmor St Baltimore
25a. REC'D BY REGISTRAR DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11817 — 11830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 (M)

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEO G. MEADE, MARYLAND
c. LENGTH OF STAY IN 1b: 3 hrs 10 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): KIMBROUGH AH FT GEO G MEADE, MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL, MARYLAND
d. STREET ADDRESS: 3 HILLCREST DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BEALL — Middle: INF — Last: MALE

4. DATE OF DEATH: Month: SEPTEMBER — Day: 3 — Year: 1967

5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 SEPT 67
9. AGE (In years last birthday): 3 HRS yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 3 — Min.: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (County & State, or foreign country): ANNE ARUNDEL, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH D. BEALL
14. MOTHER'S MAIDEN NAME: JEAN ANDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JOSEPH BEALL(F) 3 HILLCREST DRIVE LAUREL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY (575 GRAMS) — INTERVAL BETWEEN ONSET AND DEATH
7625
DUE TO (b): PRIMARY ATELECTASIS — 3 HRS,10 MIN
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3 Sept, 1967 to 3 Sept 67, 19__, that (I) (we) last saw the deceased alive on 3 Sept 1967, and that death occurred at 3:30P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] / for
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3 Sept 67
22c. PHYSICIAN'S NAME (Type): ROBERT F. CULLEN, CPT, MC
22d. ADDRESS: KIMBROUGH AH, FORT GEO G. MEADE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/6/67
23c. NAME OF CEMETERY OR CREMATORY: St Marys Cem
23d. LOCATION (City or Town) (County) (State): Laurel P. G. Md.

24. FUNERAL DIRECTOR: De Witt Donaldson — ADDRESS: Laurel, Md
25a. REC'D BY REGISTRAR DATE: SEP 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

7-28-67 W. Hammond

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11813

CERTIFICATE OF DEATH

11831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 40 Wendward Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Florida — b. COUNTY: Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Miami
d. STREET ADDRESS: 3301 N.E. 5 Ave — 483
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLA — Middle: WHITNEL — Last: BEARDSLEY

4. DATE OF DEATH: Month: 9 — Day: 10 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/16/90

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House mother

10b. KIND OF BUSINESS OR INDUSTRY: College

11. BIRTHPLACE (County & State, or foreign country): VIENNA, ILL. / INDIS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LINDORF O. WHITNEL

14. MOTHER'S MAIDEN NAME: Amanda Trainwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 324 45 15

17. INFORMANT — Address: Melville W. Beardsley — Above — 1 A, B, D

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: few minutes

4271

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. 9:05 p.m. — Month, Day, Year: 9/10/67 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Son's home

20f. (City or town): Severna Park — (County): A.A. — (State): Md.

21. **I certify** that (I) (this hospital) attended the deceased from Aug, 1967 to Sept, 1967, that (I) (we) last saw the deceased alive on Sept 10, 1967, and that death occurred at 9:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Ray M. Smith — M.D.

22b. DATE SIGNED: 9/10/67

22c. PHYSICIAN'S NAME (Type): RAY M. SMITH

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Severna Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Sept 14, 1967 — 23c. NAME OF CEMETERY/OR CREMATORY: Mt. Washington — 23d. LOCATION (City, town or county): Kansas City — (State): Missouri

24. FUNERAL DIRECTOR'S SIGNATURE: Robert S. Barranco — ADDRESS: Severna Park, Md.

25a. REC'D BY REGISTRAR DATE: SEP 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

ROBERT S. BARRANCO

Items-20&21 Film 392
9-13-67 ams

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #1d Film #G392 9/13/67 ph

11819

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11833

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel ~~General~~ Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
d. STREET ADDRESS: 137 Georgetown Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First: James — Middle: E. — Last: Bendall Jr.
4. DATE OF DEATH: Month: 9 — Day: 1 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/12/1926
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): court reporter
10b. KIND OF BUSINESS OR INDUSTRY: Reporter
11. BIRTHPLACE (State or foreign country): Md. State Roanoke, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Bendall, Sr.
14. MOTHER'S MAIDEN NAME: Metta Pattisall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): no
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Mother — Address: 137 Georgetown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Overdose of Drug (Barbiturates)
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

2 — 871.0 ✓

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): Overdose of drug
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED — While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) (County) (State): Annapolis Md.

02

21. I **certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☐, Inquiry ☐, and in my apinian death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Albert L. Anderson M.D.
EXAMINER'S NAME (Type): ALBERT L ANDERSON
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Annapolis, Md.
22. DATE SIGNED: 9/1/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 4, 1967
23c. NAME OF CEMETERY OR CREMATORY: Greenhill Cemetery
23d. LOCATION (City or Town) (County) (State): Danville Pittsylvania Va.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Beverley E. Hopping
Hopping Funeral Home - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 haurs after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral directar. Page 4 should be farwarded ta the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained far your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, ar removal, and in any event within 72 haurs after death.

VR A15ME (5)
6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11820

CERTIFICATE OF DEATH

11834

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 137 Georgetown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Metta — Middle: Pattisall — Last: BENDALL

4. DATE OF DEATH: Month: September — Day: 24 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1900

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Secretary

10b. KIND OF BUSINESS OR INDUSTRY: US Gov't.

11. BIRTHPLACE (County & State, or foreign country): Hope Mill, N.C.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry Clegg Pattisall

14. MOTHER'S MAIDEN NAME: Martha M. Odell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 162-16-4339

17. INFORMANT — Address: Mrs. Verna P. Barbee, Newland, N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb, 1967 to 9/24, 1967, that (I) (we) last saw the deceased alive on 9/24 1967, and that death occurred at 4:15 P M, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/24/67

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman M.D.

22d. ADDRESS: 16 Murray Ave, Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Greenhill Cemetery

23d. LOCATION (City or Town) (County) (State): Danville, Pittsylvania, Va.

24. FUNERAL DIRECTOR: HOPPING FUNERAL HOME — ADDRESS: Bentley E. Hopping, Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11821

CERTIFICATE OF DEATH

11835

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 1 day
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Annapolis Cape St. Claire
   d. STREET ADDRESS: Box 29, Route 4
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: H — Last: BLOCKINGER

4. **DATE OF DEATH**: Month: September — Day: 23 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 4, 1906

9. AGE (In yeors lost birthday): 60 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Inspector of Bldgs

10b. KIND OF BUSINESS OR INDUSTRY: A.A. County

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm. H. Blockinger Jr.

14. MOTHER'S MAIDEN NAME: Wahmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213104576

17. INFORMANT: Address: Mrs. Goldie Blockinger - Above

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiac Arrest
   DUE TO (b): Coronary Heart Disease with Angina Syndrome
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   4201
   INTERVAL BETWEEN ONSET AND DEATH: 1 Yr.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor / Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 1, 1967 to Sept 23, 1967 that (I) (we) last saw the deceased alive on Sept 23 1967 and that death occurred at 8:34 PM from causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-25-67

22c. PHYSICIAN'S NAME (Type): FM SHIPLEY

22d. ADDRESS: Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/27/67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.

23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.

24. FUNERAL DIRECTOR — ADDRESS: Robert S. Barranco, Severna Pk.
   ROBERT S. BARRANCO

25a. REC'D BY REGISTRAR — DATE: SEP 27 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11822

CERTIFICATE OF DEATH

11836

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Annapolis
d. STREET ADDRESS: 420 Hammond Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type ar print): First: Jennie — Middle: Shearman — Lost: BOWERS

4. **DATE OF DEATH**: Manth: September — Day: 26 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 8, 1888
9. AGE (In yeors last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of wark dane during mast af working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (County & Stote, or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: FREDERICK BOWERS
14. MOTHER'S MAIDEN NAME: ALVINA MANCHESTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Douglas Bowers — Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): left hemiparesis — INTERVAL BETWEEN ONSET AND DEATH: 96 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral embolism — 96 hrs.
DUE TO
(c): Acute myocardial infarction — 2 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II at item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☐
20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)
20f. (City ar tawn) (County) (State)

21. **I certify** thot (I) (this hospital) attended the deceased from June, 1963, to Sept., 1967, thot (I) (we) last saw the deceased alive on 9/25 1967, and thot death accurred at 12:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: John Hedermann — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/26/67
22c. PHYSICIAN'S NAME (Type): JOHN HEDERMANN
22d. ADDRESS: FOREST DR. ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-2-67
23c. NAME OF CEMETERY OR CREMATORY: OAK GROVE
23d. LOCATION (City or Town) (County) (State): FALL RIVER MASS.

24. FUNERAL DIRECTOR: John M. Foxwell Sons — ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: OCT 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11823

CERTIFICATE OF DEATH

11837

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Severna Park, Md.~~ Severn 02-1
d. STREET ADDRESS: Old Oak Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Earl — Last: Boyd
4. DATE OF DEATH: Month: September — Day: 12 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9 April 1904
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Athol Boyd
14. MOTHER'S MAIDEN NAME: Lucy A Franke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service): 1920 - 1945
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jane M. Boyd, Old Oak Road, Severn, Md. Address: 21144

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolization — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Acute myocardial infarction — 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Heart Disease — 10+ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uretero-lithiasis R
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8 Sept. , 19 67 to 12 Sept. , 1967 , that (I) (we) last saw the deceased alive on 12 Sept. 1967 , and that death occurred at 2200 P M, from causes and on the date stated above.

22a. SIGNATURE: Michael F. Fornes MD — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 13 Sept 67
22c. PHYSICIAN'S NAME (Type): MICHAEL F. FORNES LCDR MC,USN
22d. ADDRESS: Naval Hospital, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 18 Sept. 67
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Ft. Meyer, Virginia

24. FUNERAL DIRECTOR: Kirkley Funeral Home, 421 Crane Highway, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: SEP 14 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11824 — 11838

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prime Rose & Tyler Ave

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: Prime Rose & Tyler Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First MATTHEWS — Middle NMN — Last BROWN

4. **DATE OF DEATH**: Month Sept. — Day 14 — Year 19 67

5. SEX: male

6. COLOR OR RACE: negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: Mar. 24-1899

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: ********

11. BIRTHPLACE (County & State, or foreign country): A.A.Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Brown

14. MOTHER'S MAIDEN NAME: Katherine Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-32-3756

17. INFORMANT: Albert Brown — Address: Rt. 3 Arnold Md. Box 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 day

443X

DUE TO (b): Hypertensive Cardio Vascular

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Disease with Cardiac failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-18-67 19.. to 9-14-67, 19.., that (I) (we) last saw the deceased alive on 9-11-67 19.., and that death occured at ..M, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Allen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-15-67

22c. PHYSICIAN'S NAME (Type): A T ALLEN

22d. ADDRESS: 62 CATHEDRAL ST

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 18-67

23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn

23d. LOCATION (City, town or county) (State): Bestgate Rd. Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: C.E. Hicks — ADDRESS: C.E.Hicks 111 Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 22 1967

25b. REGISTRAR'S SIGNATURE: Juliaries Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11825 — 11839

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~BMX×AMBXCAX×CREXTON×XX~~ North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MD. — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
   d. STREET ADDRESS: 409 BLOSSOM LANE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROBERT — Middle: E. — Last: BURKE

4. DATE OF DEATH: Month: Sept — Day: 15 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 12-28-01

9. AGE (If years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jig & Fixture Builder

10b. KIND OF BUSINESS OR INDUSTRY: Martin Co.

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Burke

14. MOTHER'S MAIDEN NAME: Mary Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 222/05/3457

17. INFORMANT — Address: Mrs. Mary Burke (wife) Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Arteriosclerotic Heart Disease — >2 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1966, to Sept, 1967, that (I) (we) last saw the deceased alive on Sept 3rd 1967, and that death occurred at 10:40 M, from causes and on the date stated above.

22a. SIGNATURE: Hilary T. O'Herlihy M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 9-16-67

22c. PHYSICIAN'S NAME (Type): Hilary T. O'Herlihy

22d. ADDRESS: Glen Burnie, Md. 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 19, 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem'l Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: R.V. Singleton — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11826

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11840

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: AACO — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North Arundel - Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD
   b. COUNTY: AACO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: 3 Ben Mere Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: A — Last: Cabell

4. DATE OF DEATH: Month: 9 — Day: 19 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-5-65

9. AGE (In years last birthday): 2 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James N. Cabell

14. MOTHER'S MAIDEN NAME: Carol Crook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. James N. Cabell (father) Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Drowning — DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): — DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH: Instant

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): In Swimming Pool

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 9/19 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): — (County): AACO — (State): MD

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 9-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept-23, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fork of Coal Cem.

23d. LOCATION (City or Town): Alum Creek — (County): — (State): W. Virginia

24. FUNERAL DIRECTOR: R. V. Singleton — ADDRESS: Glen Burnie, Maryland

25a. REC'D BY REGISTRAR — DATE: SEP 21 1967

25b. REGISTRAR'S SIGNATURE: Charles J. Lyon

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11841

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Linthicum on Pennsylvania RR tracks

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1706 St. Paul St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First FRANCES Middle LORETTA Last CAMPBELL

4. DATE OF DEATH: Month September Day 9 Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May-30-23
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charleston, S.C.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Curtis S. Porter
14. MOTHER'S MAIDEN NAME: Naomi Parish
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 265-34-6888
17. INFORMANT: Naomi Charleston Address: 1419-E 21st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple traumatic injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
802 X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): Subject was struck by a train
20c. TIME OF INJURY Month, Day, Year Hour: 4:55 p.m. 9 9 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RR tracks
20f. (City or town) Linthicum (County) AA (State) MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R S Fisher M.D.
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
22. DATE SIGNED: September 10, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 9-11-67
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
23d. LOCATION (City or Town) Hickson's Cross Rds. (County) (State) Fla.
24. FUNERAL DIRECTOR: Thos. E. Fisher ADDRESS: 193 Eastern Ave.
25a. REC'D BY REGISTRAR DATE: SEP 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11823 11842

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02,1
d. STREET ADDRESS: 216 Severn Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: CHASE
4. DATE OF DEATH: Month: September — Day: 30 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 5, 1895
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Alfred Chase
14. MOTHER'S MAIDEN NAME: Sarah Toodal
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Grace Chase — Address: 216 Severn Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ac. Pulmonary edma — INTERVAL BETWEEN ONSET AND DEATH: 45 Min.
DUE TO (b): Arteriosclerotic C.V. disease — ?
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~had occasion to~~) attended the deceased from _____, 19____, to Sept. 30, 1967, that (I) (~~saw~~) last saw the deceased alive on Sept. 30 1967, and that death occurred at 1:30 AM from causes and on the date stated above.

22a. SIGNATURE: Maurice K Lawans M.D. — ATTENDING PHYS. XXX — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Maurice Kawans, M.D.
22d. ADDRESS: 31 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-4-1967
23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn
23d. LOCATION (City or Town) (County) (State): Annapolis Md.
24. FUNERAL DIRECTOR: William Beesch — ADDRESS: Annapolis
25a. REC'D BY REGISTRAR — DATE: OCT 2 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11823 11843

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: A. A. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St Margarets
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cape St. Clair Road

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: A. A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St Margarets 021
   d. STREET ADDRESS: Cape St. Clair Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Priscilla — Middle: — Last: Coates

4. **DATE OF DEATH**: Month: 9 — Day: 26 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-17-1888

9. AGE (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis Harris

14. MOTHER'S MAIDEN NAME: Eliza Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Marie Johnson Address: Edgewater Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiac Arrest
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH:
   4330

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-24-67, 19__ to 9-26-67, 19__, that (I) (we) last saw the deceased alive on 9-21-67 19__, and that death occurred at 1 p M, from causes and on the date stated above.

22a. SIGNATURE: Chas T. Allen — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): A.J.S. T ALLEN

22d. ADDRESS: 62 Gibbons St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-29-67

23c. NAME OF CEMETERY OR CREMATORY: Fowlers

23d. LOCATION (City or Town) (County) (State): Edgewater Md

24. FUNERAL DIRECTOR: William Reese # Annapolis Md

25a. REC'D BY REGISTRAR DATE: OCT 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11830 — 11844

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel General Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Balto. 30.4
   d. STREET ADDRESS: 1534 Carey St.
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alonzo — Middle — Last Cobb

4. DATE OF DEATH: Month Sept. — Day 27, — Year 1967

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-17-11

9. AGE (In years last birthday): 56yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, aven if ratired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Cobb

14. MOTHER'S MAIDEN NAME: Adline Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 245-03-4539

17. INFORMANT: Elaine Cobb — Address: 1534 Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH:
4200
Conditions, if any, which gava risa to immediate causa (a), stating the underlying causa last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 5, 19 67 to Sept 27, 19 67, that (I) (we) last saw the deceased alive on Sept 26 19 67 and that death occurred at 9.17 M, from the causes and on the date stated above.

22a. SIGNATURE: F. K. Adams — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 29-67

22c. PHYSICIAN'S NAME (Type): F. K. ADAMS

22d. ADDRESS: 122 N. Caroline St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-1-67

23c. NAME OF CEMETERY OR CREMATORY: Philip High Cem.

23d. LOCATION (City, town or county) (State): , North Carolina

24. FUNERAL DIRECTOR — ADDRESS: Kelson Funeral Home 1348 Calhoun St.

25a. REC'D BY REGISTRAR DATE: SEP 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11831

CERTIFICATE OF DEATH

11845

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b 1 Wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ~~Ann~~ North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Halethorpe~~ Harmans P.O.
d. STREET ADDRESS Old Coaling Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Cottrill
4. DATE OF DEATH Month Sept Day 20 Year 19 67
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan 15, 1899
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ~~Truck Driver~~ Retired
10b. KIND OF BUSINESS OR INDUSTRY Westport Mac. Co.
11. BIRTHPLACE (County & State, or foreign country) Williamsport, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME (unknown) Cottrill
14. MOTHER'S MAIDEN NAME (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) ----------
16. SOCIAL SECURITY NO. 212-03-9422A
17. INFORMANT Address Mrs. Shirley A. Howard(daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b) Emphysema-Bronchitis — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Cholecystectomy — 3 days
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-14-67, 19__, to 9-20-, 1967, that (I) (we) last saw the deceased alive on 9-20 1967, and that death occurred at 11:53 ~~P~~ M, from causes and on the date stated above.

22a. SIGNATURE Franz X Groll
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Franz X. Groll
22d. ADDRESS 11 E. Eagle Street

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9/23/67
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland

24. FUNERAL DIRECTOR Robert P. Ware ADDRESS Singleton Funeral Home? Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE SEP 25 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11832

CERTIFICATE OF DEATH

11846

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give street oddress): DOA Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town): Edgewater, M
d. STREET ADDRESS: 1130 Fairhill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MELVIN Middle HARRY Last COULTER, Sr.

4. DATE OF DEATH: Month SEPT Doy 20 Year 1967

5. SEX: male

6. COLOR OR RACE: caus.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1901

9. AGE (In years lost birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of wark done during most af working life, even if retired): grocer

10b. KIND OF BUSINESS OR INDUSTRY: own business

11. BIRTHPLACE (County & State, ar foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence C. Coulter

14. MOTHER'S MAIDEN NAME: Mary R. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates of service): no

16. SOCIAL SECURITY NO.: 578-09-2330A

17. INFORMANT (Address): Mrs. Bessie V. Coulter - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1810
IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO
Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.
(b): CARCINOMA OF BLADDER. — 6 Mo.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, form, factory, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this haspital) attended the deceased from MAY 23, 1967, ta SEPT 20, 1967, that (I) (we) last saw the deceased alive an SEPT 2 1967, and that death occurred at 3:04 PM, from causes and on the date stated above.

22a. SIGNATURE: H. Logan Holtgrewe — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/20/67

22c. PHYSICIAN'S NAME (Type): H. LOGAN HOLTGREWE

22d. ADDRESS: 16 MURRAY AVE. ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: All Hallows Cemetery

23d. LOCATION (City or Town) (County) (State): Birdsville A.A. Md.

24. FUNERAL DIRECTOR: Hopping Funeral Home - Annapolis, Md.

ADDRESS: Bentley E. Hopping

25a. REC'D BY REGISTRAR DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11838

CERTIFICATE OF DEATH

11847

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 101 Eastern Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: — Last: Cschenk

4. DATE OF DEATH: Month: 9 — Day: 14 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: April 22, 1895

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Baltimore. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James E. Fontz

14. MOTHER'S MAIDEN NAME: Elizabeth Michels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 212 03 8856

17. INFORMANT: Henry Cschenk — Address: 101 Eastern St. Glen Burnie

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO
(b): A. S. C. V. D.
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying cause lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 7, 1963 to Sept 14, 1967, that (I) (we) last saw the deceased alive an Sept 14 1967, and that death occurred at 2 °4 M, from causes and an the date stated above.

22a. SIGNATURE: Robert Dalsheim — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 9/14/67

22c. PHYSICIAN'S NAME (Type): Robert Dalsheim M.D.

22d. ADDRESS: 400 Crain Hwy N.E. Glen

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/18/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City or Town) (County) (State): Glen Burnie AA. Md.

24. FUNERAL DIRECTOR: McCully — ADDRESS: 130 E. Fort Ave. Balto.

25a. RECD BY REGISTRAR DATE: SEP 18 1967

25b. REGISTRAR'S SIGNATURE:

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11834 Item #7 Film #G393 10/11/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11848

1. PLACE OF DEATH
   a. COUNTY: A.A.CO. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL —
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 197A - Brock Bridge Road.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD — b. COUNTY: AA CO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL — 02.1
   d. STREET ADDRESS: 197A - Brock Bridge Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norbert — Middle: — Last: Dahm

4. DATE OF DEATH: Month: 9 — Day: 28 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 10/24/18

9. AGE (In years last birthday): 38 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: Bldg Trades

11. BIRTHPLACE (State or foreign country): Wausau Wisc

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ERNEST DAHM

14. MOTHER'S MAIDEN NAME: MARTHA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 1946 - 1947

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Viola Dahm — Address: Rt 1 Box 197A Laurel Brock Bridge Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiorespiratory Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instant
   DUE TO (b): Coronary Occlusion
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):
   581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D.

EXAMINER'S NAME (Type): E Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 9.28.67

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: Sept 29 1967

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): ~~Laurel~~ Bladensburg Md

24. FUNERAL DIRECTOR: Lothrop Walters — ADDRESS: 550 Washington Blvd Laurel

25a. RECD BY REGISTRAR: OCT 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11835

CERTIFICATE OF DEATH

11849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 107 Glendale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: B. — Last: Davidson

4. DATE OF DEATH: Month: 9 — Day: 25 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-2-80

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Town-Yale

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James R. Davidson

14. MOTHER'S MAIDEN NAME: Mary Whorley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dates of service): None

16. SOCIAL SECURITY NO.: 224-09-0221

17. INFORMANT: Mrs. Roxie B. Schemm (Daughter) — Address: Same as # 2
Patient's Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis with
DUE TO (b): Congestive heart failure
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
DUE TO (c): Hypertension
Arteriosclerosis
4201
Urinary tract infection

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/18/67, 19__ to 9/25, 1967, that (I) (we) last saw the deceased alive on 9/24 1967, and that death occurred at 1:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: E. G. de Guzman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/26/67

22c. PHYSICIAN'S NAME (Type): B. A. deGuzman, MD.

22d. ADDRESS: 204 Crain Hwy. S. Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 28/ 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City or Town) (County) (State): Glen Bunrie, Maryland

24. FUNERAL DIRECTOR: E. B. Flannery

ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Snyder

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11836

CERTIFICATE OF DEATH

11850

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Employee Md. House of Correction

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30-4
d. STREET ADDRESS: 3305 Southern Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Edward — Last: Deets, Sr.

4. DATE OF DEATH: Month: Sept. — Day: 24 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 17, 1906.

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Md. House of Correction.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Milton Deets

14. MOTHER'S MAIDEN NAME: Mary Weber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): 1920--1928

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Clara B. Deets — Address: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, acute
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
4201
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1, 1965, to 9-23, 1967, that (I) (we) last saw the deceased alive on 9-24 1967, and that death occurred at M, from causes and on the date stated above.

22a. SIGNATURE: Sebastian Russo M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/25/67

22c. PHYSICIAN'S NAME (Type): SEBASTIAN RUSSO M.D.

22d. ADDRESS: 5017 Harford Rd Balto Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/28/67.

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, Inc Baltimore, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Yaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 4 Item 18 Film 39
10-4-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11837 11851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): City - Annapolis
d. STREET ADDRESS: 113 Ridgely Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bessie — Middle: — Last: DICKSON

4. **DATE OF DEATH**: Month: September — Day: 23, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 1, 1890.

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Leroy BROWN

14. MOTHER'S MAIDEN NAME: Millie Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 493-38-8308

17. INFORMANT: Beulah Dickson — Address: 113 Ridgely Ave

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Perforati of colon. — INTERVAL BETWEEN ONSET AND DEATH: Days
153.8
DUE TO
(b): Cancer Carcinoma of colon. — Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/2[illegible], 1906, to 9/23/67, 19__, that (I) (we) last saw the deceased alive on September 23 19 67, and that death occurred at 10:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: Gerard Calvert — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/2/67

22c. PHYSICIAN'S NAME (Type): Gerard Calvert

22d. ADDRESS: 121 Clayton Rd Ext Annapolis

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-30-1967

23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn

23d. LOCATION (City or Town) (County) (State): Annapolis Md

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Anna. Md.

25a. RECD BY REGISTRAR DATE: SEP 27 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11838

CERTIFICATE OF DEATH

11852

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): ANNE ARUNDEL GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~ANNAPOLIS~~ Hanover (RURAL) 021
d. STREET ADDRESS: Box 18, Ridge Road ~~BAY MANOR NURSING HOME~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine Middle: S. Lost: Dowgalski
4. DATE OF DEATH: Month: Sept Doy: 6 Year: 1967
5. SEX: F
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1875
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Ret)
10b. KIND OF BUSINESS OR INDUSTRY: Self-Emp.
11. BIRTHPLACE (County & State, or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Karl Demcyznski
14. MOTHER'S MAIDEN NAME: Rosley Demerski
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): NO —
16. SOCIAL SECURITY NO.: 214-20-6288
17. INFORMANT: Eleanor L. Heil Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
332X
DUE TO
(b): Pneumonia, right lung — 3days
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
DUE TO
(c): Cerebral thrombosis with right hemiparesis — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Degenerative arthritis, pyelonephritis,
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 4, 1967, to Sept 6, 1967, that (I) (we) last saw the deceased alive an Sept 5 1967, and that death occurred at 4:15A M, from causes and on the date stated abave.

22a. SIGNATURE: Charles W. Kinzer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept 6, 1967
22c. PHYSICIAN'S NAME (Type): CHARLES W. KINZER, M.D.
22d. ADDRESS: 16 MURRAY AVE, ANNAPOLIS, MD 21401

23a. BURIAL, CREMATION, REMOVAL (Specify): ENTOMBMENT
23b. DATE THEREOF: 9/9/67
23c. NAME OF CEMETERY OR CREMATORY: Lorraine Mausoleum
23d. LOCATION (City or Town) (County) (State): Woodlawn, Md.
24. FUNERAL DIRECTOR: R. P. Ware - Singleton Funeral Home
ADDRESS: Glen Burnie
25a. REC'D BY REGISTRAR DATE: SEP 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11839 11853

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville ANNAPOLIS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. A. A. General Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville 02-1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Edward — Last: Easton

4. **DATE OF DEATH**: Month: Sept. — Day: 24 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-18-1918

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab-oner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Vernon Easton

14. MOTHER'S MAIDEN NAME: Annie Foote

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 213-05-0021

17. INFORMANT: Henretta Easton — Address: Galesville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Few minutes
DUE TO (b): Coronary arteriosclerosis — year
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe diabeter mellitus & peripheral vascular disease (double amputee of legs)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1960, to Sept 24, 1967, that (I) (~~we~~) last saw the deceased alive on Sept. 3 1967, and that death occurred at 1130 pM, from causes and on the date stated above.

22a. SIGNATURE: Willard F Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/25/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD

22d. ADDRESS: Shady Side, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-30-67

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer

23d. LOCATION (City or Town) (County) (State): Galesville Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: SEP 27 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11840 Item #2c & d Film #G392 9/18/67 ph 11854

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis St. Margarets
d. STREET ADDRESS: Rt. #2 Revell Hwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: M. — Last: Ehle

4. DATE OF DEATH: Month: 9 — Day: 9 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 6-9-1875

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ? Priest

14. MOTHER'S MAIDEN NAME: ? Woodward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Nursing Home #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Cholecystitis Chronic & acute — few days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occurred at 2:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R.M. Smith M.D.

22b. DATE SIGNED: Sept 9 1967

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): R.M. Smith

22d. ADDRESS: Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-11-67

23c. NAME OF CEMETERY OR CREMATORY: St. Margarets

23d. LOCATION (City, town or county): St. Margarets (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11841

CERTIFICATE OF DEATH

11855

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 121 Smith Ave., 02,1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Ellsworth — Last: EMERICK

4. DATE OF DEATH: Month: September — Day: 29 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1912

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumbing

10b. KIND OF BUSINESS OR INDUSTRY: Boat building

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GROVER EMERICK

14. MOTHER'S MAIDEN NAME: LILLIAN BRANZELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. MARY M. EMERICK — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ruptured aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.,
DUE TO
(b): hypertensive cardiovascular disease c — 10 yrs.
DUE TO
(c): marked arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(Accident)~~ attended the deceased from Sept. 29, 19 67, to ZSept. 29, 19 67 that (I) ~~(Acc)~~ last saw the deceased alive an Sept. 29 19 67, and that death occurred at 6:40 PM from causes and an the date stated above.

22a. SIGNATURE: Samuel Borssuck M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/2/67

22c. PHYSICIAN'S NAME (Type): Samuel Borssuck, M.D.

22d. ADDRESS: Amos Garrett Blvd., Annanpolis, Md.

23a. BURIAL, ~~CREMATION,~~ REMOVAL (Specify)

23b. DATE THEREOF: 10-2-1967

23c. NAME OF CEMETERY OR CREMATORY: HILLCREST CEM.

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS — ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: OCT 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11842

CERTIFICATE OF DEATH

11856

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 414 Second St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: Vernon — Last: EVANS

4. DATE OF DEATH: Month: September — Day: 18 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 16, 1896

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (County & State, or foreign country): Calvert Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm DANIEL BOYD

14. MOTHER'S MAIDEN NAME: MARY PRICILLA DALRYMPLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHN T. EVANS — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (b): Acute myocardial infarction — 1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from July, 1963, to Sept. 18, 1967, that (I) (☒) last saw the deceased alive on Sept. 18 1967, and that death occurred at 2:30 PM M, from causes and on the date stated above.

22a. SIGNATURE: John L. Hedeman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/19/67

22c. PHYSICIAN'S NAME (Type): John L. Hedeman, M.D.

22d. ADDRESS: 1407 Forest Drive,, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: SEPT 21 1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF CEM.
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR · SONS
ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: SEP 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11843

11857

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 705 Delaware Ave., N/E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Roger — Last: FARMER Jr.

4. DATE OF DEATH: Month: September — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1914

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Electrical

11. BIRTHPLACE (County & State, or foreign country): Baltimore City, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William R. Farmer Sr.

14. MOTHER'S MAIDEN NAME: Margaret Medicus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): //////////

16. SOCIAL SECURITY NO.: 212/07/2780

17. INFORMANT: Mrs. Lillian M. Farmer — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiogenic shock — INTERVAL BETWEEN ONSET AND DEATH: 3 hr.
DUE TO (b): Acute myocardial infarction — 3 hr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from Sept. 25, 19 67, to 9/28, 19 67, that (I) last saw the deceased alive on 9/28 19 65, and that death occurred at 12:45 M, from causes and on the date stated above.

22a. SIGNATURE: Richard N. Peeler M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/28/67

22c. PHYSICIAN'S NAME (Type): Richard N. Peeler, M.D.

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem'l Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Robert P. Ware — ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: OCT 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11844

CERTIFICATE OF DEATH

11858

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 10 20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie (Baltimore)
   c. LENGTH OF STAY IN 1b: 8 weeks / XX years
   d. NAME OF HOSPITAL OR INSTITUTIDN (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY DR TOWN (If outside corporate limits, write RURAL and give neorest town): Glen Burnie (Baltimore) Linthicum
   d. STREET ADDRESS: #410 Forest View Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY — Middle E. — Last FINLEY

4. DATE OF DEATH: Month Sept. — Doy 21 — Year 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-16-20

9. AGE (In yeors lost birthday): 47 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical

10b. KIND OF BUSINESS OR INDUSTRY: Union News

11. BIRTHPLACE (County & State, or foreign country): Starkeville, Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Hilliard

14. MOTHER'S MAIDEN NAME: Victorial Overdowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no

16. SOCIAL SECURITY NO.: 220 09 8232

17. INFORMANT — Address: Mr. Jacob E. Finley (husband) Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Carcinoma Breast c Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 3 Yrs
   DUE TO (b):
   DUE TO (c):
   Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.
   170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceosed from Feb, 19 67, to 4-21, 19 67, thot (I) (we) lost saw the deceased alive on 4-20- 19 67, and that death accurred at 8 p. M., from causes and an the date stated abave.

22o. SIGNATURE: C B Mc Donald MD — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 25/67

23c. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR — ADDRESS: R. V. Singleton — SINGLETON FUNERAL HOME, Glen Burnie, Maryland

25o. REC'D BY REGISTRAR — DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11845

CERTIFICATE OF DEATH

11859

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 3621--Nichols Ave., SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edwin — Middle: Francis — Last: Fogerty

4. DATE OF DEATH: Month: Sept. — Day: 15 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 Sept. 1893

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd. Col. U. S. A. F.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, DC

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Fogerty

14. MOTHER'S MAIDEN NAME: Mary Manning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes WW I (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 577-56-1640

17. INFORMANT — Address: Maud E. Fogerty-Wife-Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): CONGESTIVE HEART FAILURE — @ 11 mos.
DUE TO
(c): ARTERIOSCLEROTIC HEART DISEASE — 10+ years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from DOA, 19___, to ___, 19___, that (I) (we) last saw the deceased alive on 15 SEPT 67 19___, and that death occurred at 6:35 M, from causes and on the date stated above.

22a. SIGNATURE — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 15 Sept. 1967

22c. PHYSICIAN'S NAME (Type): M. F. FORNES, LCDR-MC USN

22d. ADDRESS: Naval Hospital, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-18-1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

23d. LOCATION (City or Town) (County) (State): Suitland Md

24. FUNERAL DIRECTOR — ADDRESS: Simmons Bros. -1661-Good Hope Rd SE Wash DC

25a. REC'D BY REGISTRAR — DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11846 — 11860

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton — 027
d. STREET ADDRESS: Beale-Churchton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earl — Middle: W. — Last: Fountain
4. DATE OF DEATH: Month: Sept. — Day: 23 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-13-1908
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Benjamin Fountain
14. MOTHER'S MAIDEN NAME: Mary Hester Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 217-07-3390
17. INFORMANT: Mary T. Wills — Address: Phila Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Rheumatic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lobar Pneumonia, rt. lung
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1959 to Sept. 23, 1967, that (I) (we) last saw the deceased alive on Sept 22 1967, and that death occurred at 7 PM, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/25/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-27-67
23c. NAME OF CEMETERY OR CREMATORY: Franklin
23d. LOCATION (City or Town) (County) (State): Beale Md.

24. FUNERAL DIRECTOR: William Reese # Anna Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: SEP 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11847

CERTIFICATE OF DEATH

11861

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Naval Hospital, Annapdis, Md.

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Annapolis — 02-1
   d. STREET ADDRESS: Apt.205 Farragut Ct.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: BABY GIRL — Middle: — Lost: FRENCH

4. **DATE OF DEATH**: Month: September — Doy: 14 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 Sept. 1967

9. AGE (In years lost birthday) — yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 8 — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, ~~even if~~ retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis O. French

14. MOTHER'S MAIDEN NAME: Giselle ? Clary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: N.A.

17. **INFORMANT** Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): IMMATURITY (7760) — INTERVAL BETWEEN ONSET AND DEATH
776X
DUE TO
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Haur a.m. p.m. — 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___ to _____, 19___, that (I) (we) last saw the deceased alive on 14 Sept. 19 67, and that death occurred at 1840 PM, from causes and on the date stated above.

22a. SIGNATURE: Robert L Shirley — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/15/1967

22c. PHYSICIAN'S NAME (Type): R. L. SHIRLEY LCDR MC USN

22d. ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/15/1967

23c. NAME OF CEMETERY OR CREMATORY: U.S. Naval Academy

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: Taylor & Sons Funeral Home — ADDRESS: Annapolis, Md.

25a. RECD BY REGISTRAR DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11848 — 11862

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Rural Baltimore
   c. LENGTH OF STAY IN 1b: 24 days
   d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Riverview, Lawnsdowne
   d. STREET ADDRESS: 2902 Freeway, Riverview
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: — Last: Fritz

4. DATE OF DEATH: Manth: 9 — Day: 17 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-3-1889

9. AGE (In years last birthday): 78 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Leonard Forrester

14. MOTHER'S MAIDEN NAME: Harriett Garble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 213-26-1743

17. INFORMANT — Address: Mr. Charles Fritz 369 Rt 2 Glen Burnie Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
   443 X
   DUE TO (b): Hypertensive Cardiovascular disease
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
   DUE TO (c): Senility, Arteriosclerosis

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia - Hypochromic, Pneumonia, Jaundice

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/29, 1967, to 9/17, 1967 that (I) (we) last saw the deceased alive an 9/17, 1967, and that death occurred at 6 PM, from causes and an the date stated above.

22a. SIGNATURE: Guillermo S. Linsao M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): GUILLERMO S. LINSAO

22d. ADDRESS: 7308 Furnace Branch Rd. Glen Burnie Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/20/67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.

23d. LOCATION (City or Tawn) (County) (State): 2930 Bedrick Rd. Md.

24. FUNERAL DIRECTOR: John J. Cowan & Son Inc. — ADDRESS: 224 Collins St.

25a. REC'D BY REGISTRAR DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingst

MARYLAND STATE DEPARTMENT OF HEALTH

11845 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ANNE ARUNDEL — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE — c. LENGTH OF STAY IN 1b: 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL HOSPITAL	d. STREET ADDRESS: 458 PHIRNE COURT E. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: JAMES	Middle	Last: GASCOYNE	4. DATE OF DEATH	Month: SEPTEMBER	Day: 16	Year: 1967	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: SEPTEMBER 11, 1874	9. AGE (In years last birthday): 93 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist	10b. KIND OF BUSINESS OR INDUSTRY: Retired	11. BIRTHPLACE (County & State, or foreign country): RICHMOND, VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME: Eliza Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 220-07-8234	17. INFORMANT — Address: Mrs Elizabexth Van Ormer Glen Burnie, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Acute Myocardial infarction
DUE TO (c): Arter in Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/11/67 19__ to 9/16/67 19__, that (I) (we) last saw the deceased alive on 9/15/67 19__, and that death occurred at 6:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: B RAMIREZ M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type): J. B. Ramirez M.D.	22d. ADDRESS: 3927 Annapolis Rd Balto 21 1672 North Brun Rd Balto 12		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 9/19/67	23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge	23d. LOCATION (City or Town) (County) (State): Baltimore, co. Md.	
24. FUNERAL DIRECTOR — ADDRESS: Wm. Cook-Brooks Inc. Baltimore, Md. 21202		25a. REC'D BY REGISTRAR DATE: SEP 20 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11850 — 11864

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen ~~Marley~~ Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marley, Glen Burnie, P. O. 021
d. STREET ADDRESS: 1204 B. & A. Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle Adolph — Last Gerland
4. DATE OF DEATH: Month September — Day 9 — Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/21/1901
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Home Building
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Louis Gerland
14. MOTHER'S MAIDEN NAME: Keltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 213-10-0742
17. INFORMANT: Evelyn Gerland (Wife) — Address: As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200
INTERVAL BETWEEN ONSET AND DEATH: Months / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 1965, to Sept, 1967, that (I) (we) last saw the deceased alive on August 1967 and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Hilary MacKay
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-10-67
22c. PHYSICIAN'S NAME (Type): H. TOHERLIHY
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/13/67
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: Raymond C. Fink
ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

ATTORNEY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11851

CERTIFICATE OF DEATH

11865

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): North Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — 02-1
d. STREET ADDRESS: Silver Sands North Shore Dr. Rt 1 Box 290
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: J — Last: Glass
4. DATE OF DEATH: Month, Doy, Year: September 3, 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 21, 1 886
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U/ S. A.
13. FATHER'S NAME: George Glass
14. MOTHER'S MAIDEN NAME: Hannah Herrman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Carl Glass Rt 1 Box 290 Glen Burnie — Address: 21061

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (b): ASCVHD — years
DUE TO (c):
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) this hospital) attended the deceased from Sept 1, 19 67 to Sept 3, 19 67, that (I) we) last saw the deceased alive an Sept 3 19 67, and that death accurred at 5:15 P M, from causes and an the date stated above.

22a. SIGNATURE: David Abramson — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/5/67
22c. PHYSICIAN'S NAME (Type): David Abramson
22d. ADDRESS: 237 Belle Annap Blvd Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/7/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City or Town) (County) (State): Anne Arundel Co. Md.

24. FUNERAL DIRECTOR: McCully Funeral Home — ADDRESS: 237 Patapsco Ave
25a. REC'D BY REGISTRAR — DATE: SEP 6 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11852

CERTIFICATE OF DEATH

11866

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville GLEN BURNIE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville, Md.
d. STREET ADDRESS: Glen Burnie, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: L. — Last: Hall

4. DATE OF DEATH: Month: Sept. — Day: 12 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-13-93
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Hall
14. MOTHER'S MAIDEN NAME: Martha E. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patients Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c): Cerebro Vascular Accident — months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility, Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 5, 19 67, to Sept 12, 19 67 that (I) (we) last saw the deceased alive on Sept 12 19 67, and that death occurred at 6:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Max Frank M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/13/67
22c. PHYSICIAN'S NAME (Type): Max Frank, M.D.
22d. ADDRESS: Arundel Medical Group, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/15/67
23c. NAME OF CEMETERY OR CREMATORY: John Insley
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: William Reese Jr. — ADDRESS: Pasadena, Md.
25a. REC'D BY REGISTRAR DATE: SEP 13 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11853

CERTIFICATE OF DEATH

11867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Millersville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Knollwood Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arunde
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: 217 Sunset Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: MINNIE Middle: B. Last: HICKS

4. **DATE OF DEATH**: Month: Sept Day: 20 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 5, 1888

9. AGE (In years last birthday): 78 yrs.
   IF UNDER 1 YEAR: Months: Days:
   IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Unknown) Aydelett

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 229-20-3646A

17. INFORMANT: Mr. Robert L. Hicks, Jr. Address: Rt. #1 — Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a): Left Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO (b): Cerebro vascular accident — months.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/31, 1967 to 9/20, 1967 that (I) (we) last saw the deceased alive on 9/20 1967, and that death occurred at 1:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/20/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 425 SE Ritchie Hwy Glen Burnie MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 23/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City, town or county) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton

ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 5-63

[redacted]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11954

CERTIFICATE OF DEATH

11868

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie,
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton 021
   d. STREET ADDRESS: Rt. 1 Box 1153
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Rosie — Middle: W. — Last: Hill

4. **DATE OF DEATH**: Month: 9 — Day: 10 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-95

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Rutland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathaniel Hawkins

14. MOTHER'S MAIDEN NAME: Juliana Spriggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Evelyn Hill — Address: Odenton Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardio Vascular Accident
   4221
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Arterio sclerosis
   DUE TO
   (c):

   INTERVAL BETWEEN ONSET AND DEATH:

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/8/67, 19__ to 9/10, 19 67 that (I) (we) last saw the deceased alive on 9/10 1967, and that death occurred at 10:25 P M, from causes and on the date stated above.

22a. SIGNATURE: J. B. Ramirez — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. B. RAMIREZ

22d. ADDRESS: 3427 ARM APOLIP RD Route 2 / 1672 NORTH BOURNE RD Bally 2

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-14-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor

23d. LOCATION (City or Town) (County) (State): Chesterfield Md

24. FUNERAL DIRECTOR: William Reese # — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR: DATE SEP 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Jenger

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11855

CERTIFICATE OF DEATH

11869

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 326 S. East Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Edward Last: Hoffman.

4. DATE OF DEATH: Month: Sept Day: 16 Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 17 1905

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Bruno Hoffman

14. MOTHER'S MAIDEN NAME: Nettie Milberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):

16. SOCIAL SECURITY NO.: 213-10-1392

17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis
083.0
DUE TO
(b): Post Encephalitic Parkinsonism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome due to the above.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Alleged by Beaten

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Crownsville Hospital

20f. (City or town) Crownsville (County) (State) Md

21. I certify that (I) (this hospital) attended the deceased from 9/8, 19 67 to 9/16, 19 67, that (I) (we) last saw the deceased alive on 9/16 19 67, and that death occurred at 8:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Lionel Henry Mapp M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/10/67

22c. PHYSICIAN'S NAME (Type): Lionel Henry Mapp MD

22d. ADDRESS: Crownsville State Hospital, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-19-67

23c. NAME OF CEMETERY OR CREMATORY: Baeto-Cemet

23d. LOCATION (City or Town) (County) (State): Balto.

24. FUNERAL DIRECTOR: Thelma A. Hoffman ADDRESS: 3218 Hudson Ave

25a. REC'D BY REGISTRAR DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11856

CERTIFICATE OF DEATH

11870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 603 Dreams Landing
   e. IS RESIDENCE ON A FARM? YES ☐ ND ☒

3. **NAME OF DECEASED** (Type or print): First: Warren — Middle: Clifton — Last: HOLSTON

4. **DATE OF DEATH**: Month: September — Day: 25 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 12, 1886

9. AGE (In years last birthday): 81 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Commercial Artist

10b. KIND OF BUSINESS OR INDUSTRY: Outdoor Advertising

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William H. Holston

14. MOTHER'S MAIDEN NAME: Lucinda Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 215-07-0953

17. INFORMANT: Lucinda Langley — Address: 603 Dreams Landing

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): CVA; Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: +2-3 days
   DUE TO (b): Severe ASCVD
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):
   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic pneumonitis; Cardiacarrest; Ribfractures; Pneumothorax

19. WAS AUTOPSY PERFORMED? YES ☒ ND ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Aug. , 19 67 , to Sept 25 , 19 67 that (I) ~~(we)~~ last saw the deceased alive on 9-25 19 67 and that death occurred at 4:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: Peter F. Verkouw — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-26-67

22c. PHYSICIAN'S NAME (Type): Peter F. Verkouw M. D.

22d. ADDRESS: 1407 Forest Drive, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 9/26/67

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City or Town) (County) (State): Washington 18, D.C.

24. FUNERAL DIRECTOR: Charles F. Bell Jr. — ADDRESS: Hopping Funeral Home Annapolis, Md. 21401

25a. REC'D BY REGISTRAR — DATE: SEP 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11857 — 11871

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
   c. LENGTH OF STAY IN 1b: 7 months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL CONVALESCENT CENTER

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: BALTIMORE
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE — 30.4
   d. STREET ADDRESS: 811 ST. PAUL ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: VIRGINIA — Middle: DARE — Last: HOOD

4. **DATE OF DEATH**: Month: SEPTEMBER — Day: 27 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

8. DATE OF BIRTH: NOV. 11, 1910

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Pvt. homes

11. BIRTHPLACE (County & State, or foreign country): ELKINS, WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM ?

14. MOTHER'S MAIDEN NAME: LILLIAN BLAKEMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-24-6167

17. **INFORMANT** Address: Hogg Records - I.D.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized cachexia, Left Metacarpal fracture — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b): Carcinomatosis Generalized — Months
DUE TO (c): Carcinoma of Rectum — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 154 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 7, 1967, to Sept 27, 1967 that (I) (we) last saw the deceased alive on Sept 27 1967, and that death occurred at 5:30 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/28/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 425 SE Ritchie Hwy - Glen Burnie MD 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/29/67

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem

23d. LOCATION (City or Town) (County) (State): Woodlawn Balto Md

24. FUNERAL DIRECTOR: Robert S. Barranco, Severna Pk. MD — ADDRESS — ROBERT S. BARRANCO

25a. REC'D BY REGISTRAR DATE: OCT 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1334
175cm

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11856

CERTIFICATE OF DEATH

11872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 year 2 mon
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30.4
d. STREET ADDRESS: 304 N. Avenure
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Zeno — Middle: G. — Last: Howard

4. **DATE OF DEATH**: Month: 9 — Day: 24 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 7/21/07

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Divid Howard

14. MOTHER'S MAIDEN NAME: Cora Rouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: unknown

17. **INFORMANT** Address: Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
493 ✓
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 2
DUE TO (c): 1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): hypertension, alcoholic D.T.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY occurred. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/25, 19 66, to 9/24/, 19 67, that (I) (we) last saw the deceased alive on 9/24/ 19 67 and that death occurred at 7:30 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/25/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 10-5-67

23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: W. Reese — ADDRESS: 108 W. Washington St.

25a. REC'D BY REGISTRAR DATE: OCT 6 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11859

CERTIFICATE OF DEATH

11873

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Forest Glen Dr., Rt. 7, Box 281
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle D. — Last HUPFL,Sr.
4. DATE OF DEATH: Month September — Day 15 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 3, 1919
9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): plumber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Nicholas Hupfl
14. MOTHER'S MAIDEN NAME: Catherine Barber
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes give war or dates of service) W.W.II
16. SOCIAL SECURITY NO.: 217-01-6321
17. INFORMANT — Address: Mary E. Hupfl - same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ASCVHD & Myocardial Ischemia
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 7/11/67, 19__, to 8/14/67, 19__, that (I) (we) last saw the deceased alive an 8/14/67 19__, and that death occurred at 5:10 P M, from causes and an the date stated above.

22a. SIGNATURE: Andrew R Sosnowski M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 15,1967
22c. PHYSICIAN'S NAME (Type): Andrew R. Sosnowski, M.D.
22d. ADDRESS: 4016 Ritchie Hgwy., Baltimore 21225

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept.18,1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce — 4001 Ritchie Hgwy., Baltimore
25a. REC'D BY REGISTRAR — DATE: SEP 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11860 — 11874

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater — 021
d. STREET ADDRESS: Rt 3 Box 865
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther — Middle: D. — Last: Ihrig
4. DATE OF DEATH: Month: Sept. — Day: 9 — Year: 1967
5. SEX: female
6. COLOR OR RACE: caus.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 23, 1905
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): teacher
10b. KIND OF BUSINESS OR INDUSTRY: public school
11. BIRTHPLACE (County & State, or foreign country): Bradford, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Milton Deuel
14. MOTHER'S MAIDEN NAME: Susie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 219-26-8257
17. INFORMANT: Harvey W. Ihrig — Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cicatrix Hemorrhagic Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Diabetes Mellitus
DUE TO (c): Hypertensive cardio Vascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/6/67, 19__, to 9/6/67, 19__, that (I) (we) last saw the deceased alive on 9/9/67, 19__, and that death occurred at __ M. from the causes and on the date stated above.

22a. SIGNATURE: Guillermo S. Linsao M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/11/67
22c. PHYSICIAN'S NAME (Type): Guillermo S. Linsao, M.D
22d. ADDRESS: 7308 Furnace Branch Rd. Glen Burnie Md. 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City, town or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR: HOPPING FUNERAL HOME — ADDRESS: Bonnie E. Hopping / Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: SEP 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11861

CERTIFICATE OF DEATH

11875

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Crownsville
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Baltimore
d. STREET ADDRESS: 1421 Lexington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last Jackson
4. DATE OF DEATH: Month 9/ — Day 7 — Year 19 67
5. SEX: M
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 10/1922
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind at work done during most at working life, even if retired): Handyman
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nanley Jackson
14. MOTHER'S MAIDEN NAME: Bessie Hooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Hospital Records, Crownsville Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease
DUE TO
Canditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Cirrhosis of liver; alcoholism Chronic Brain Syndrome
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City ar tawn) (County) (State)

21. **I certify** that (I) (this hospitol) attended the deceased from 3/23, 19 60, to 9/7, 19 67, that ~~(I)~~ (we) last saw the deceosed olive an 9/7, 19 67, and that deoth occurred at 7:15 M, from causes ond an the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 9/8/67
22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/11/1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
23d. LOCATION (City or Town) (County) (State): Cedar Hill Md.

24. FUNERAL DIRECTOR: Williams Funeral Home
ADDRESS: 3199 Solomons
25a. REC'D BY REGISTRAR — DATE SEP 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11862

CERTIFICATE OF DEATH

11876

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: —
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville c. LENGTH OF STAY IN 1b: 19 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Crownsville State Hospital	d. STREET ADDRESS: 1059 Myrtle Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Arabell	Middle	Lost: Jasper	4. DATE OF DEATH	Month: 9	Doy: 7	Year: 1967	
5. SEX: F	6. COLOR OR RACE: Negro	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 9/8/94	9. AGE (In years lost birthday): 73 yrs.	IF UNDER 1 YEAR: Months / Doys	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic Work	10b. KIND OF BUSINESS OR INDUSTRY: ----------	11. BIRTHPLACE (County & Stote, or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY?: U.S.A.					
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: Hospital Records, Crownsville Maryland						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Dehydration and Inanition
DUE TO (c):
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.
493X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizphrenic Reaction TBC(?) old intestinal obstruction surgically repaired
002.1
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐	20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	20f. (City or town) (County) (Stote)	

21. **I certify** that (I) (this hospital) attended the deceased from 11/26/ , 1948, to 9/7/ , 1967, that (I) (we) last saw the deceased alive on 9/7/ 1967, and that death occurred at 12:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐	22b. DATE SIGNED: 9/7/67	
22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.	22d. ADDRESS: Crownsville State Hospital, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 9/11/67	23c. NAME OF CEMETERY OR CREMATORY: Arlington Mem. Park	23d. LOCATION (City or Town) (County): Baltimore Co.	(State): Md
24. FUNERAL DIRECTOR: Robert E. Kuttler	ADDRESS: 3035 W. North Ave.	25a. REC'D BY REGISTRAR DATE: SEP 15 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11863 — 11877

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Severna Park
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Earleigh Hgts Rt 2 Box 400

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A.A.Co
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Severna Park — 02-1
   d. STREET ADDRESS: Earleigh Hgts Rt2 Box 400
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosa — Middle: Lee — Last: Jennings

4. DATE OF DEATH: Month: Sept — Day: 19 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-12-1896

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ******

11. BIRTHPLACE (County & State, or foreign country): Amelia Co, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Jackson

14. MOTHER'S MAIDEN NAME: Henrietta ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): ********

16. SOCIAL SECURITY NO.: 216-36-1410

17. INFORMANT: Beatrice Brown — Address: 62 Demarest St Newark, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocordial Infarction — INTERVAL BETWEEN ONSET AND DEATH

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.C.V.D.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1958, 19___, to 1967, 19___, that (I) (we) last saw the deceased alive on 9-16 1967, and that death occurred at 6 P M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R Hahn M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-19-67

22c. PHYSICIAN'S NAME (Type): Robert R. Hahn

22d. ADDRESS: Severna Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-23-67

23c. NAME OF CEMETERY OR CREMATORY: Asbury Town neck

23d. LOCATION (City, town or county) (State): A.A. Co Md

24. FUNERAL DIRECTOR ADDRESS: C.E. Hicks, 111 Annapolis, Md

25a. REC'D BY REGISTRAR DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11864 Item #1d Film #U392 9/8/67 ph 11878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kimbrough Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4331 DuBois Place S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DONALD — Middle D. — Last JOHNSON

4. DATE OF DEATH: Month September — Day 2, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 4/2/39

9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse Aid
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Johnson

14. MOTHER'S MAIDEN NAME: Annie Mae McNeil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Annie Mae Rollins, Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lacerations of heart and right lung
DUE TO
(b): Crushing injury of chest
DUE TO
(c): C
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 823.4

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of auto - collided with tree

20c. TIME OF INJURY Month, Day, Year — Hour a.m. 2:00 ~~XX~~ 9-2- 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street

20f. (City or town) (County) (State): Fort Meade Anne Arundel

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: September 2, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/7/67
23c. NAME OF CEMETERY OR CREMATORY: Columbia
23d. LOCATION (City or Town) (County) (State): Columbia, S.C.

24. FUNERAL DIRECTOR — ADDRESS: Charles A. Rice 661 W. Barre St

25a. REC'D BY REGISTRAR DATE: SEP 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11865 — 11880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: //////
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Pasadena 02-1
   d. STREET ADDRESS: 201 Mission Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Gladys — Middle: D. — Lost: Johnson

4. **DATE OF DEATH**: Month: September — Day: 22 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-13-04

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry T. Donaldson

14. MOTHER'S MAIDEN NAME: Bertha Suehle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
    (If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: Unknown

17. **INFORMANT** — Address: Mrs. Helen Gross (sister) Glen Burnie, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Acute Myocardial infarction
    DUE TO (b): Arteriosclerosis
    DUE TO (c):
    Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.
    4201
    INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHF

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Manth, Doy, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/15/67, 19___, to 9/22/67, 19___, that (I) (we) last saw the deceased alive on 9/21/67 19___, and that death occurred at 12:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: J. B. Ramirez — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/27/67

22c. PHYSICIAN'S NAME (Type): J. B. RAMIREZ

22d. ADDRESS: 3527 ANNAPOLIS RD Balto 21 / 1672 NORTHBOURNE RD Balto 21

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 25/ 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Singleton Funeral Home — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 27 1967

25b. REGISTRAR'S SIGNATURE: Juliana Jungen

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11868

CERTIFICATE OF DEATH

11881

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Muddy Creek Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: William — Last: JOHNSON
4. DATE OF DEATH: Month: Sept. — Day: 30 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1896
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction
10b. KIND OF BUSINESS OR INDUSTRY: **********
11. BIRTHPLACE (County & Stote, or foreign country): Anne Arundel, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Johnson
14. MOTHER'S MAIDEN NAME: Molly Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give wor or dotes of service): WW 1
16. SOCIAL SECURITY NO.: 214-05-1417
17. INFORMANT: Walter Johnson, Harwood, A.A.Co, Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal obstruction, cause unknown?
DUE TO (b): Incarcerated rt. inguinal hernia?
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
5610
INTERVAL BETWEEN ONSET AND DEATH: 10 hours / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~his hospital~~) attended the deceased from Jan, 1967, to Sept. 30 1967, that (I) (~~we~~) last saw the deceased alive on Sept. 30, 1967, and that death occurred at 8:50 PM from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/2/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, M.D.
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-5-1967
23c. NAME OF CEMETERY OR CREMATORY: Church of God
23d. LOCATION (City or Town) (County) (State): A.A.Co. Md

24. FUNERAL DIRECTOR — ADDRESS: C.E. Hicks, III 43-NW St, Annapolis, Md
25a. REC'D BY REGISTRAR DATE: OCT 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11867 Item #1d Film #G393 9/27/67 ph — 11882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1. **PLACE OF DEATH**
   a. COUNTY: A A Co. — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Shady Side
   c. LENGTH OF STAY IN 1b: 1week
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Private Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Penna. — b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
   d. STREET ADDRESS: 650 N. WADE AVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: STUART — Middle: CURTIS — Last: JOHNSON

4. **DATE OF DEATH**: Month: SEPT — Day: 15 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 24, 1903

9. AGE (In years last birthday): 64 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (County & State, or foreign country): MICHIGAN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: STUART CLARK JOHNSON

14. MOTHER'S MAIDEN NAME: BERTHA CURTIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 178-09-0177

17. INFORMANT: VIRGINIA JOHNSON — Address: WASHINGTON, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO (b): Hypertensive cardiovascular disease — over 20 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased ~~from~~ Sept 15, 1967 to ~~19~~, that (I) (we) last saw the deceased ~~alive~~ on Sept 15, 1967, and that death occurred at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept 16, 67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD

22d. ADDRESS: Shady Side, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9-19-67

23c. NAME OF CEMETERY OR CREMATORY: WASHINGTON ~~PENNA.~~

23d. LOCATION (City, town or county) (State): WASHINGTON, PENNA

24 FUNERAL DIRECTOR'S SIGNATURE: HARDESTY FUNERAL HOME — ADDRESS: Galesville, Md

25a. REC'D BY REGISTRAR DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jarboe

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11865 — 11879

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): c Arnold, Maryland
d. STREET ADDRESS: Joyce Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louisa — Middle: DENSON — Last: JOYCE

4. DATE OF DEATH: Month: September — Day: 24 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December 27, 1900
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: BERNARD W. DENSON
14. MOTHER'S MAIDEN NAME: VERA T. LAMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 214 26 0255
17. INFORMANT: DENSON W. Higgins — Address: 42

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock
DUE TO
(b): Intestinal obstruction
DUE TO
(c): Fibrous band compressing the ileum.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
570.5

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept, 19 67 to Sept 24, 19 67 that (I) (we) last saw the deceased alive on 9/24 19 67, and that death occurred at 10:15 A.M. 10:55 P.M. from causes and on the date stated above.

22a. SIGNATURE: Francis L. Codd M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-26-67
22c. PHYSICIAN'S NAME (Type): FRANCIS I. Codd
22d. ADDRESS: Severna Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-27-67
23c. NAME OF CEMETERY OR CREMATORY: BALDWIN MEMORIAL
23d. LOCATION (City or Town) (County) (State): MILLERSVILLE MD.

24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE OCT 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11869

CERTIFICATE OF DEATH

11883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Annapolis
d. STREET ADDRESS: 2606 Green Briar Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: Frances — Lost: KENDRICK

4. DATE OF DEATH: Month: September — Doy: 7 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 25, 1899

9. AGE (In yeors last birthdoy): 67 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): Chicago, Ill.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Edward Barrington

14. MOTHER'S MAIDEN NAME: Elizabeth Barrington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Emily Reichert — Address: 2606 Greenbr-ar Lane, Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerotic Heart Disease — 8 YEARS
DUE TO (c):
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1953, to 7 SEPT, 1967, that (I) (we) last saw the deceased alive on 7 SEPT 1967, and that death occurred at 6:45 P.M. from causes and on the date stated above.

22o. SIGNATURE: Edward S. Beck M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/67

22c. PHYSICIAN'S NAME (Type): Edward S. Beck, M.D.

22d. ADDRESS: 73 Franklin St., Annapolis, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 11 1967

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

23d. LOCATION (City or Town) (County) (Stote): Annapolis, Md.

24. FUNERAL DIRECTOR: Beall Funeral Home — ADDRESS: 1212 West St. Anna

25o. REC'D BY REGISTRAR DATE: SEP 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11871

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: A.A.Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: ///////
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North Arundel Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD — b. COUNTY: AACO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Homeland - rd. - 02-1
d. STREET ADDRESS: 1013 - Ritchie Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: A — Last: Kinsey
4. DATE OF DEATH: Month: 9 — Day: 16 — Year: 19 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: April 29, 1920
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger
10b. KIND OF BUSINESS OR INDUSTRY: Beth Steel
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Leo J. Kinsey, Sr.
14. MOTHER'S MAIDEN NAME: Lottie Elizabeth Warfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW-II
16. SOCIAL SECURITY NO. 215-07-7100
17. INFORMANT (Brother) Mr. Raymond Kinsey — Address: 7808 Harbor Dr. Orchard Beach Balto. 21226

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: C. Kinsey M.D.
EXAMINER'S NAME (Type): E. Kinsey
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 9-16-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/19/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Richard V. Singleton — ADDRESS: Glen Burnie, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11872

CERTIFICATE OF DEATH

11886

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: since 8/14/67

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 6 30.4
d. STREET ADDRESS: 4820 GREENCREST ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): CROWNSVILLE State Hospital

3. NAME OF DECEASED (Type or print): First ARTHUR Middle Reed Last KIRBY

4. DATE OF DEATH: Month 9 Day 3 Year 1967

5. SEX: M
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 10/15/1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STREET CAR DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: Ba. Tr. Transit Co.
11. BIRTHPLACE (County & State, or foreign country): BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: JAMES KIRBY
14. MOTHER'S MAIDEN NAME: ANNA SHIELDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 213-10-2505A
17. INFORMANT Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b): CHRONIC BRAIN SYNDROME AGS. & ARTERIOSCLEROSIS — since admission
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/14/67, 19__ to 9/3/67, 19__, that (I) (we) last saw the deceased alive on 9/3/67 19__, and that death occurred at 1.45 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐
22b. DATE SIGNED: 9/3/67
22c. PHYSICIAN'S NAME (Type): L BENEDICT M.D.
22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/7/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem
23d. LOCATION (City or Town) (County) (State): A.A. Co. Md.

24. FUNERAL DIRECTOR: McCully Funeral Home ADDRESS: 30 E Fort Ave
25a. REC'D BY REGISTRAR DATE: SEP 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Juggo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

M

11870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11884

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margaret's
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): White Hall Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margaret's
d. STREET ADDRESS: White Hall Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: OLIVER — Middle: K. — Last: KNAUTH

4. DATE OF DEATH: Month: September — Day: 28, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 6 JUNE 1912

9. AGE (In years last birthday): 55 ~~56~~ yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WRITER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NEW YORK.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: OSWALD KNAUTH

14. MOTHER'S MAIDEN NAME: ANNA CLEMENS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: ROBT. C. CABOT, 2 PLEASANT ST., S. NATICK, MASS.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive and arteriosclerotic cardiovascular disease
443 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: September 28, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 20 OCT. 67

23c. NAME OF CEMETERY OR CREMATORY: GREEN MOUNT CREM.

23d. LOCATION (City or Town) (County) (State): BALTO, MD.

24. FUNERAL DIRECTOR — ADDRESS: ULLRICH FUNERAL HOME, BALTO., MD.

25a. REC'D BY REGISTRAR DATE: OCT 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11873 — 11887

1. PLACE OF DEATH
a. COUNTY: A.A. Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 104 Hatton Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A.A. Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: 104 Hatton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle JOSEPH Last KOPECKY

4. DATE OF DEATH: Month 9 Day 16 Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-27-21

9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Control Negotiator

10b. KIND OF BUSINESS OR INDUSTRY: NASA

11. BIRTHPLACE (State or foreign country): NEBRASKA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank J Kopecky

14. MOTHER'S MAIDEN NAME: Emma Kutelek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): yes WW II

16. SOCIAL SECURITY NO.: 507124667

17. INFORMANT: Mrs. Martha Ellen Kopecky — Address: above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot Head - L — INTERVAL BETWEEN ONSET AND DEATH: Instan
DUE TO (b): Self Inflicted Injury
DUE TO (c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gun shot wound - Self Inflicted.

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 9:16 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) AACo (County) (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Lambert M.D.
EXAMINER'S NAME (Type): E. Lambert
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 9-16-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-21-67
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l
22d. LOCATION (City, town, or county): Arlington (State) Va.

23. FUNERAL DIRECTOR: Robert S. Barranco, Severna Park, Md.
ROBERT S. BARRANCO
ADDRESS

24a. REC'D BY REGISTRAR DATE: SEP 25 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11874

CERTIFICATE OF DEATH

11888

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 032
d. STREET ADDRESS: 14 Broadship Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Effie; Middle: ; Last: Koser
4. DATE OF DEATH: Month: 9/; Day: 19; Year: 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: ? 1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT BISEL unknown
14. MOTHER'S MAIDEN NAME: MARY H. RETALLICK unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Hospital Records, Crownsville Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute ulcerative cystitis — INTERVAL BETWEEN ONSET AND DEATH
6000
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute bilateral pyelonephritis with abscess formations
DUE TO
(c): Intertrochanteric fracture, left hip(operated)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Cerebral Arteriosclerosis, Anemia, moderate
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/23, 1963, to 9/19, 1967, that (I) (we) last saw the deceased alive on 9/19, 1967, and that death occurred at 6:30 a M, from causes and on the date stated above

22a. SIGNATURE: C. Dorkan M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9/20/67
22c. PHYSICIAN'S NAME (Type): C. Dorkan, M.D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept 22/67
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn
23d. LOCATION (City or Town) (County) (State): Balto Co Md

24. FUNERAL DIRECTOR: Wilhelm Lundt Home — ADDRESS: Dundalk Md
25a. REC'D BY REGISTRAR — DATE: SEP 25 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, ordinarily within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11875

CERTIFICATE OF DEATH

11889

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): QUEEN BORDEN Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): CROWNSVILLE STATE HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: BURNIE Anne Co.
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): P.O. BOX 462
d. STREET ADDRESS: Glen Burnie
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First STELLA Middle B. Lost LEMONS
4. DATE OF DEATH: Manth SEPTEMBER Doy 15 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-26-83
9. AGE (In yeors last birthdoy): 84 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): ~~Md~~ Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Reuben Horn
14. MOTHER'S MAIDEN NAME: Josephine Donovan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 232-24-2565
17. INFORMANT: Mr. William Sauers Address: P.O. Box 462 Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HYPOSTATIC PNEUMONIA
6000
DUE TO
(b): ACUTE PYELONEPHRITIS W/ ABSCESS FORMATION
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
INANITION ; CHRONIC BRAIN SYNDROME .

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 4/5, 19 67, to 9/15, 19 67, that (I) (we) last saw the deceased alive on 9-15 1967, and that death occurred at 6:55 M, from causes and on the date stated above.

22a. SIGNATURE: M. G. Lakshman Rao M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: Sept 16 · 1967
22c. PHYSICIAN'S NAME (Type): M · G. LAKSHMAN RAO
22d. ADDRESS: CROWSVILLE STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/20/67
23c. NAME OF CEMETERY OR CREMATORY: Trissels Cem
23d. LOCATION (City or Town) (County) (Stote): Broadway Va.
24. FUNERAL DIRECTOR: McCully-Mef
ADDRESS: 237 Patapsco Ave Balto Md 21225
25a. REC'D BY REGISTRAR DATE: SEP 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11876

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11890

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Texas — b. COUNTY: Dallas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mesquite
d. STREET ADDRESS: 4821 Sandrelynn Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

80.3

3. NAME OF DECEASED (Type or print): First: Barney — Middle: T. — Last: Long
4. DATE OF DEATH: Month: 9 — Day: 1 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/4/12 ~~2/4/06~~
9. AGE (In years last birthday): ~~55~~ 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintanance
10b. KIND OF BUSINESS OR INDUSTRY: A.T.&S.F.
11. BIRTHPLACE (State or foreign country): Big Springs, Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Long
14. MOTHER'S MAIDEN NAME: Mary Ann Abney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ////////
16. SOCIAL SECURITY NO.: 525/05/4299
17. INFORMANT: Mrs. Ethelee Long — Address: Same As # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: C.H. Wirth, MD, M.D.
EXAMINER'S NAME (Type): Charles H. Wirth, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)

22. DATE SIGNED: 9/1/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: Edgewood Cemetery
23d. LOCATION (City or Town) (County) (State): Edgewood, Texas

24. FUNERAL DIRECTOR: R.V. SINGLETON, ADDRESS: GLEN BURNIE, MD.
25a. REC'D BY REGISTRAR DATE: SEP 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11877

CERTIFICATE OF DEATH

11891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1125 Eastport Terrace

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 1125 Eastport Terrace
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ANTONETTE — Middle YVONNE — Last LOWE

4. **DATE OF DEATH**: Month Sept. — Day 15 — Year 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1936

9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: *******

11. BIRTHPLACE (County & State, or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Lowe

14. MOTHER'S MAIDEN NAME: Ethel Strickney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-56-0299

17. INFORMANT: Hattie Forrester - 1125 Eastport Terrace — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Palsy - Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

334 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-14-67, 19..., to 9-15-67, 19..., that (I) (we) last saw the deceased alive on 9-14-67, 19..., and that death occured at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Allen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-15-67

22c. PHYSICIAN'S NAME (Type): A.T. ALLEN

22d. ADDRESS: Cathedral Street Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 18-67

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City, town or county) (State): Annapolis, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: C.E. Hicks

ADDRESS: 111 Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 22 1967

25b. REGISTRAR'S SIGNATURE: Orphans Judge

Items 20a & b. Film #39
9-13-67 mt

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11894

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 518 First St.
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First: Peter — Middle: Harold — Last: MAYHEW

4. DATE OF DEATH: Month: September — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED X — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: April 12, 1941

9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Maintenance -State

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John M. Mayhew, Sr.

14. MOTHER'S MAIDEN NAME: Mary C. Come

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 216-36-7100

17. INFORMANT — Address: Mrs. Betty Mayhew - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed Skull
DUE TO (b): Fracture Left thigh (Immediate)
DUE TO (c): Fracture Rt forearm
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse last.
8234

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.): Car in which he was driving hit a tree stump

20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m.: 2:25 xx — 9/1 1967

20d. INJURY OCCURRED While at work ☐ — Not While at work X

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry ☐, and in my opinion death resulted from: Naturol causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Albert L. Anderson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX
EXAMINER'S NAME (Type): Albert L. Anderson, M.D.
Address (Street, city, town, or county): 44 Southgate Ave., Annapolis, Md.

22. DATE SIGNED: 9/1/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 4, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. Md.

24. FUNERAL DIRECTOR — ADDRESS: Hopping Funeral Home - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11873 — 11892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1. PLACE OF DEATH
a. COUNTY: A A Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rt. 1 - Box 70

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY: Camden
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haddonfield
d. STREET ADDRESS: 110 Hutchinson Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Irvin — Middle: Johnston — Last: Matlack

4. DATE OF DEATH: Month: 9-19-67 — Day: — Year: 19

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 12, 1884

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WATSON MATlack

14. MOTHER'S MAIDEN NAME: MARY WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-26-6146

17. INFORMANT: William E. MATlack — Address: Crownsville, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): C.V.D.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1964, 19__, to 1967; 19__, that (I) (we) last saw the deceased alive on 9-10-67, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn. — M.O. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-19-67

22c. PHYSICIAN'S NAME (Type): Robert R. HAHN.

22d. ADDRESS: P.O. Box 73 Severna Park md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/23/67

23c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery

23d. LOCATION (City, town or county) (State): Camden Co. New Jersey

24. FUNERAL DIRECTOR: Robert Pugsley — ADDRESS: Singleton Funeral Home / Glen Burnie, md

25d. REC'D BY REGISTRAR DATE: SEP 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11880 — 11893

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 4 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 25 W. Washington St.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Tammy — Middle: Tashew — Last: Matthew

4. **DATE OF DEATH**: Month: September — Day: 30 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 30, 1967

9. AGE (In years lost birthday): — yrs.

IF UNDER 1 YEAR: Months — Days — Hours: 4 — Min.: 00

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ormond Matthew

14. MOTHER'S MAIDEN NAME: Betty Ann Coates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — Atelectasis
DUE TO
(b): Prematurity
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

7625

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Premature birth

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~knew~~) attended the deceased from Sept. 30, 1967, to Sept. 30 1967, that (I) (~~xx~~) last saw the deceased alive on Sept. 30 1967, and that death occurred at 4:45 PM from causes and on the date stated above.

22a. SIGNATURE: James E Wheeler, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/3/67

22c. PHYSICIAN'S NAME (Type): Jonathan McC. Sutton, M.D.

22d. ADDRESS: 201 Forbes St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-4-67

23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Reese

ADDRESS: Anna Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11881

CERTIFICATE OF DEATH

11896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rte. 7, Box 328, Grey's Creek Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: AA
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Rte. 7, Box 328, Grey's Creek Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

021

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: L. — Last: Melvin

4. DATE OF DEATH: Month: Sept. — Day: 20, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5 Sept. 1889

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed

10b. KIND OF BUSINESS OR INDUSTRY: Ret.

11. BIRTHPLACE (County & State, or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Melvin

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Eleanora Melvin, same as 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary arteriosclerotic heart disease — 4½ years

DUE TO (c): Cardiac decompensation — 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5/24, 1963, to 9/20, 1967, that (I) (~~we~~) last saw the deceased alive on 9/19 1967 and that death occurred at 4P M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/20/67

22c. PHYSICIAN'S NAME (Type): Randall McLaughlin, M. D.

22d. ADDRESS: 3708 Mountain Road, Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 25 Sept. 67

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11882

CERTIFICATE OF DEATH

11897

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town):
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Ellicott City
d. STREET ADDRESS: 17 Amherest Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Stanford — Lost: Newsome

4. DATE OF DEATH: Month: September — Doy: 13 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 15, 1920
9. AGE (In years lost birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: W R Grace Co
11. BIRTHPLACE (County & Stote, or foreign country): Ahoskie, N.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hoard Newsome
14. MOTHER'S MAIDEN NAME: Bruce Estelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service): 1937-1957
16. SOCIAL SECURITY NO.: 565-48-4970
17. INFORMANT: Mrs Robert Newsome — Address: 17 Amherst Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cardiac Arrest
DUE TO
(b): Acute Myocardial Infarction
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) ottended the deceased from 13 SEP, 1967, to 13 SEP, 1967, that (I) (we) last saw the deceased alive on 13 SEP 1967, and that death occurred at 9:20 PM, from couses ond on the date stated above.

22a. SIGNATURE: x Stanley L Kampner M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 13 Sep 67
22c. PHYSICIAN'S NAME (Type): STANLEY L KAMPNER, CPT, MC
22d. ADDRESS: KIMBROUGH ARMY HOSPITAL FT MEADE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 17 '67
23c. NAME OF CEMETERY OR CREMATORY: Crest Lawn
23d. LOCATION (City or Town) (County) (Stote): Marriottsville Howard Co.

24. FUNERAL DIRECTOR: Howard County Funeral Home — ADDRESS: Harry H. Witzke Ellicott City Md.
25a. REC'D BY REGISTRAR — DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11888 — 11898

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: A A Co — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Knollwood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arundel Gardens — 02-1
d. STREET ADDRESS: 418 Creswell Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: T — Last: Owen

4. DATE OF DEATH: Month: Sept — Day: 13 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 22, 1888

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (County & State, or foreign country): Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Henry Owen

14. MOTHER'S MAIDEN NAME: Olena Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 223-18-7398

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: Hours Days
DUE TO (b): Acute pulmonary edema
DUE TO (c): Chronic asthma

241X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Emphysema, Chronic Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/14, 1967, to 9/13, 1967, that (I) (we) last saw the deceased alive on 9/13 1967, and that death occurred at 6:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: Max C Frank MD — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/14/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 425 SE Ritchie Hwy Glen Burnie Md 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/16/67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem

23d. LOCATION (City, town or county) (State): Glen Burnie Md

24. FUNERAL DIRECTOR — ADDRESS: McCully F.H. 737 Catalpa Ave 21225

25a. REC'D BY REGISTRAR DATE: SEP 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

D.R.F.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11884

CERTIFICATE OF DEATH

11899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: —
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville c. LENGTH OF STAY IN 1b: 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital	d. STREET ADDRESS: 1122 Myrtle Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Bernice		Palmer	9	8	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	Negro		2/21/22	45 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Beautician	----------	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Palmer	~~Theresa~~ Harrissa Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
unknown	unknown	Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

583X

IMMEDIATE CAUSE (a): Hepatic failure
DUE TO (b): Chirrhosis of liver or Generalized Carcinomatosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia Severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/31/ , 1967, to 9/8/ , 1967, that (I) (we) last saw the deceased alive on 9/8/ 19 67 and that death occurred at 7:15 M, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Lionel McHenry Mapp, M.D.					9/8/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Lionel McHenry Mapp, M.D.	Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-12-67	Mount Auburn	Baltimore

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Mans Funeral Home	638 N Gilmor St	SEP 11 1967	J. Charles Judge

1/67

pital, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11885

CERTIFICATE OF DEATH

11900

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 5A Carver St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RUDOLPH — Middle: WILLIAMS — Last: PARKER

4. DATE OF DEATH: Month: September — Day: 28 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SD2

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy Ret

11. BIRTHPLACE (County & State, or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alonzo Williams

14. MOTHER'S MAIDEN NAME: Sarah Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-34-4160

17. INFORMANT: Minnie Parker 5A Carver St. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMPHYSEMA
527.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 18 Sept., 19 67, to 28 Sept., 1967, that (I) (we) last saw the deceased alive on 28 Sept. 1967, and that death occurred at 1355 M, from causes and on the date stated above.

22a. SIGNATURE: M. F. FORNES, LCDR MC USN
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9-28-67

22c. PHYSICIAN'S NAME (Type): M. F. FORNES, LCDR MC USN

22d. ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 3-67

23c. NAME OF CEMETERY OR CREMATORY: St. Marys

23d. LOCATION (City or Town) (County) (State): Annapolis, Maryland

24. FUNERAL DIRECTOR: Charles E. Hicks III — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: OCT 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11901

1. **PLACE OF DEATH**
   a. COUNTY: A.A.Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA-PK.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.OA-NORTH ARUNDEL-Hosp

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD — b. COUNTY: AACO.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA-PARK. MD 21
   d. STREET ADDRESS: RR1-Box 318
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: CLARA — Middle: FLORENCE — Last: PATTERSON

4. **DATE OF DEATH**: Month: 9 — Day: 4 — Year: 1967

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NET-LAOOER

10b. KIND OF BUSINESS OR INDUSTRY: RUBBER HEEL CO

11. BIRTHPLACE (State or foreign country): NORTHUMBERLAND VA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM TAYLOR

14. MOTHER'S MAIDEN NAME: ADA HUDNALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-22-2363

17. INFORMANT: FRED. PATTERSON — Address: SEVERNA PK. MD

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instan
   DUE TO (b): Pulmonary Embolism
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
   260 X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.
EXAMINER'S NAME (Type): E. LINHARDT.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 9-4-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9-7-67 — 23c. NAME OF CEMETERY OR CREMATORY: MT CALVARY — 23d. LOCATION (City or Town) (County) (State): BROOKLYN, A.A.Co, MD

24. FUNERAL DIRECTOR: Mansfield & Hays — ADDRESS: 638 N Gilmor St

25a. REC'D BY REGISTRAR DATE: SEP 7 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

A34 10/18/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11887 — 11902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: #1307 Meadowvale
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: CHARLOTTE — Middle: — Last: PEACOCK
4. DATE OF DEATH: Month, Day, Year: September 13, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 11, 1909
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beautician
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (County & State, or foreign country): Pittsburgh, Pennsy.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Lever
14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): ////////////
16. SOCIAL SECURITY NO.: 201 14 5561
17. INFORMANT — Address: Mr. Glen Peacock (husband) Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
4341
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: 11 30 a.m. p.m. — Month, Day, Year: 9 13 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from February, 1967, to Sept. 13, 1967, that (I) (We) last saw the deceased alive on 9-13 1967, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wayne B. Tate M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): WAYNE B. TATE, M.D.
22d. ADDRESS: 108 Central Ave Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 18/67
23c. NAME OF CEMETERY OR CREMATORY: Alleghany Co., Mem. Park
23d. LOCATION (City, town or county) (State): Pittsburgh, Pennsy.

24. FUNERAL DIRECTOR'S SIGNATURE: R V Singleton
ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11888 — 11903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 11 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Pasadena
d. STREET ADDRESS: Rt-2, Box-193
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rena — Middle: Dolores — Last: PERRY

4. DATE OF DEATH: Month: September — Day: 13 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 6, 1887

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Milliner (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Fashion Millinery

11. BIRTHPLACE (County & State, or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Erving A. Roe

14. MOTHER'S MAIDEN NAME: Rena Swist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): ////////

16. SOCIAL SECURITY NO.: 217 14 6310A

17. INFORMANT — Address: Mrs. Ruth E. Eckert (daughter) same as#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Mo.
170X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): Primary Carcinoma Breast — 2 YRS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~saw the body~~) attended the deceased from _____, 1962, to Sept. 13 1967, that (I) (~~we~~) last saw the deceased alive on Sept. 13 1967, and that death occurred at 7:15 AM from causes and on the date stoted above.

22a. SIGNATURE: Arthur Lankford Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Arthur Lankford, Jr.
22d. ADDRESS: 2934 Mountain Road, Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 16/67
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: A. P. Singleton
ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland
25a. REGISTRAR'S DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11889 — 11904

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deale
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Drum Point Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deale
d. STREET ADDRESS: Deale Beach — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CLARENCE — Middle: VINSON — Last: Phipps
4. DATE OF DEATH: Month: Sept. — Day: 6 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
8. DATE OF BIRTH: July 23, 1918
9. AGE (In Years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPERVISOR
10b. KIND OF BUSINESS OR INDUSTRY: BOAT YARD
11. BIRTHPLACE (County & State, or foreign country): Deale, Md
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Guy Phipps
14. MOTHER'S MAIDEN NAME: CLORA ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1943-46
16. SOCIAL SECURITY NO.: 217 16 7249
17. INFORMANT — Address: Bertha Anderson, Deale, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrhythmia - ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Arteriosclerotic heart disease and — 9 months
DUE TO (c): previous myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 19 66 to Sept 6 19 67, that (I) (we) last saw the deceased alive on Sept. 6 19 67, and that death occurred at 1:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/7/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD
22d. ADDRESS: Shady Side, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-9-67
23c. NAME OF CEMETERY OR CREMATORY: Mt Zion.
23d. LOCATION (City or Town) (County) (State): Lothian, Md AA Co

24. FUNERAL DIRECTOR — ADDRESS: Hardesty Funeral Home, Galesville, Md
25a. REC'D BY REGISTRAR DATE: SEP 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

11890

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 736 Patterson Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

30.4

06

3. NAME OF DECEASED (Type or print): First (Sophie) Sophia; Middle M.; Last Popiolek

4. DATE OF DEATH: Month 9; Day 29; Year 1967

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/4/92

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic work

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Smith

14. MOTHER'S MAIDEN NAME: Rosie Ann ~~X~~ Chew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO. 214-14-5978

17. INFORMANT Address: Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fluid and Electrolyte Imbalance
DUE TO
(b): Intestinal obstruction
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
570.5
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome due to Cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/7/ 65, to 9/29 67, that (I) (we) last saw the deceased alive an 9/29 1967, and that death occurred at 1:30 M, from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/29/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/2/67.

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, Inc. Balto. Md. 21214

25a. REC'D BY REGISTRAR DATE: OCT 2 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #G392 9/19/67 ph

11891

CERTIFICATE OF DEATH

11906

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 6 Bristol Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Annapolis Nursing & Convalescent Center

3. NAME OF DECEASED (Type or print): First: Fannie — Middle: May — Lost: Potter

4. DATE OF DEATH: Month: Sept. — Day: 12 — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W		1-7-1883	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (County & State, or foreign country): PRINCESS ANNE Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CALEB BEACHAM
14. MOTHER'S MAIDEN NAME: NANCY HARRISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: E. B. Potter — Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure
DUE TO (b): Angina Pectoris
DUE TO (c): Senility
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
794X
INTERVAL BETWEEN ONSET AND DEATH: undetermined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1960 to 9-12, 1967, that (I) ~~(we)~~ last saw the deceased alive on Sept 12 1967, and that death occurred at 4:00 M, from causes and on the date stated above.

22a. SIGNATURE: W. P. Stephens — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12 Sept 1967
22c. PHYSICIAN'S NAME (Type): W. P. STEPHENS
22d. ADDRESS: Cornhill St Annapolis, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-13-67
23c. NAME OF CEMETERY OR CREMATORY: St. Anne's
23d. LOCATION (City or Town) (County) (State): Annapolis MD.

24. FUNERAL DIRECTOR: John M. Loyd & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: SEP 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11892 — 11907

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 1/2 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Annapolis Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 833
d. STREET ADDRESS: 5035-36th Street North
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Valentine — Middle: — Last: Richter Sr.
4. DATE OF DEATH: Month: Sept — Day: 8 — Year: 67
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/14/84
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Buyer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Richter
14. MOTHER'S MAIDEN NAME: Frederika Strauss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. William H. Adrian — Address: 5035 N. 36th St. Arlington, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Complete heart block
DUE TO (c): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 67, to Sept 9, 1967, that (I) (we) last saw the deceased alive on Aug 9 1967, and that death occurred at 11:30 M, from causes and on the date stated above.

22a. SIGNATURE: Willard F Smith — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/9/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith
22d. ADDRESS: Shady Side, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/11/67
23c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens Cem.
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Mac H. Morris — Arlington Funeral Home — ADDRESS: 3401 N. Fairfax Drive Arlington Virginia
25a. REC'D BY REGISTRAR — DATE: SEP 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11893 — 11908

FOR STATE HEALTH DEPT. USE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
d. STREET ADDRESS: Route 1 Box 7B Hanover, M.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LENA — Middle: G. — Last: ROGERS

4. DATE OF DEATH: Month: September — Day: 12 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 22, 1910

9. AGE (In years last birthday) 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Al Greene Ent.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Loughry

14. MOTHER'S MAIDEN NAME: Ethel Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no ////////////

16. SOCIAL SECURITY NO.: 219 10 3979

17. INFORMANT — Address: Mr. Russell R. Rogers (husband) same as2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Traumatic injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse lost.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Subject's car was struck by train

20c. TIME OF INJURY Month, Doy, Yeor Hour: 12 p.m. 9 12 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RR Track

20f. (City or town) Balto. (County) ANNE Ar. (State) Md.

21. I certify that I taak charge of the remains described above, held an Autapsy ☒, Inspection ☐, Inquiry ☐, and in my apinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. S. Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county): September 13, 1967
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 16/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: P. Singleton — ADDRESS: Singleton Funeral Home Glen Burnie, Maryland

25a. REGISTRAR — DATE: SEP 18 1967

25b. [illegible]

VR A15ME (5-67) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MS-Reg 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11894 — 11909

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

99

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel Co — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis MD
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Arundel Gen Hospt

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Middle River-Balto. County 032
   d. STREET ADDRESS: 324 Grovetown Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First Charles — Middle A. — Last Rosengarn

4. **DATE OF DEATH**: Month 9 — Day 2 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/20/1912

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Wise Potato Chips

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Rosengarn

14. MOTHER'S MAIDEN NAME: Minnie Fruend

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-01-7810

17. INFORMANT — Address: Charles A. Rosengarn JR - Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute dilatation of the Heart — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4344
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Albert L. Anderson M.D.
EXAMINER'S NAME (Type): ALBERT L. ANDERSON
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): 425 Cathedral, Balto.

22. DATE SIGNED: 9/7/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/5/67

23c. NAME OF CEMETERY OR CREMATORY: Oakland

23d. LOCATION (City or Town) (County) (State): Balto. Md.

24. FUNERAL DIRECTOR — ADDRESS: Joseph N. Zannino, Jr. 263 S. Conkling St.

25a. REC'D BY REGISTRAR DATE: SEP 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11895 — 11910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Convalescent Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore — 21230
d. STREET ADDRESS: 1438 Richardson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip (Philip) — Middle: — Last: Rossbach

4. DATE OF DEATH: Month: 9 — Day: 27 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/9/1884

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? Russia

13. FATHER'S NAME: Phillip Rossbach

14. MOTHER'S MAIDEN NAME: Elizabeth Mildenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 215-09-3299A

17. INFORMANT: Mrs. Marie Rossbach — Address: 1438 Richardson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (b): General arteriosclerosis — years
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): no.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): —

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19: —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐: —

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) (County) (State): —

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Feb. 2, 1963, to Sept. 27, 1967, that (I) ~~(we)~~ last saw the deceased alive on Sept. 23, 1967, and that death occurred at 10:15 ~~P.M.~~ from the causes and on the date stated above.

22a. SIGNATURE: C. C. Chiu — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-28-67

22c. PHYSICIAN'S NAME (Type): C. C. Chiu, M. D.

22d. ADDRESS: 1 E. Randall Street, Baltimore Md. 21230

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/30/67

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION (City, town or county) (State): Anne Arundel, Md.

24. FUNERAL DIRECTOR ADDRESS: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue

25a. REC'D BY REGISTRAR DATE: SEP 29 1967

25b. REGISTRAR'S SIGNATURE: Florence Yinger

VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11896

CERTIFICATE OF DEATH

11911

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): City - Annapolis 02-1
d. STREET ADDRESS: 908 Van Buren Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Estelle — Last: SEGELKEN

4. DATE OF DEATH: Month: September — Day: 23, — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 15, 1896
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (County & State, or foreign country): Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: J. E. MORELAND
14. MOTHER'S MAIDEN NAME: CLARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: HENRY F. SEGELKEN — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACVD c Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO (b): & Chronic Pyelonephritis — 4 Yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1963 to 9.23.67 that (I) (we) last saw the deceased alive on September 23 1967, and that death occurred at 5:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9.25.67
22c. PHYSICIAN'S NAME (Type): F.M. SHIPLEY
22d. ADDRESS: Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-26-67
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS A.A. MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE SEP 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11897 — 11912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 25 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 405 Maple Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theresa — Middle: C. — Last: Shute

4. DATE OF DEATH: Month: September — Day: 24 — Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-1-99
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lawrence Ferrari
14. MOTHER'S MAIDEN NAME: Helen Olivito

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes give war or dates of service): No None
16. SOCIAL SECURITY NO.: 079-18-9353
17. INFORMANT: Mr. Clarence E. Shute (husband) — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): C V A
DUE TO (b): arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/20/67, 19__ to 9/24/67, 19__, that (I) (we) last saw the deceased alive on 9/13/67 19__, and that death occurred at 3:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: Jorge B. Ramirez — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Jorge Ramirez, MD
22d. ADDRESS: 3527 Annapolis Rd Balto 21 / 1612 North Bouvard Balto 21

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/27/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: E. B. Singleton — ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11898

CERTIFICATE OF DEATH

11913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Manor NURSING Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1925 Christian St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First JULIA Middle A. Last Sickel (Sickle)

4. **DATE OF DEATH**: Month Sept Day 20 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/18/92
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late-Henry Geldmacker
14. MOTHER'S MAIDEN NAME: Late-Emma Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of servica):
16. SOCIAL SECURITY NO.:
17. **INFORMANT** Address: Mr. Samuel G. Sickel 1925 Christian St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Left Ventricular failure	Hours
DUE TO (b)	Septicemic Shock	Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Post Cerebro Vascular accident	Months

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/7, 1967 to 9/20, 1967 that (I) (we) last saw the deceased alive on Sept 20 1967, and that death occurred at 12:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Max C Frank MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/19/67
22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD
22d. ADDRESS: 425 SE Ritchie Hwy - Glen Burnie Md 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/22/67
23c. NAME OF CEMETERY OR CREMATORY: Crest Lawn Cem.
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Witzke F. D. - 4101 Edmondson Av.
25a. REC'D BY REGISTRAR DATE: SEP 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
2DM S-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11898

CERTIFICATE OF DEATH

11914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 107 Tolson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Alice — Middle: V — Last: Single

4. **DATE OF DEATH**: Month: 9 — Day: 7 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-6-1885

9. AGE (In years last birthday) yrs.: 82

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Chase, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip Bramble

14. MOTHER'S MAIDEN NAME: Minnie Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grace Stallings — Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Sept, 1967 to 7 Sept, 1967 that (I) (we) last saw the deceased alive an 1 Sept 1967, and that death occurred at 5:30 P.M. from causes and an the date stated above.

22a. SIGNATURE: Edward S. Beck — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/67

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: Franklin St. Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-10-67

23c. NAME OF CEMETERY OR CREMATORY: St. Margarets

23d. LOCATION (City or Town) (County) (State): St. Margarets Md

24. FUNERAL DIRECTOR: John M. Lyles & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE SEP 13 1967

25b. REGISTRAR'S SIGNATURE: Frances Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11900

CERTIFICATE OF DEATH

11915

1. PLACE OF DEATH
a. COUNTY: Q Q — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Z. B. C.
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Na. An. G. H.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: B ALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Balto City — 03-7
d. STREET ADDRESS: 903 Victory Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lawrence — Middle: A. — Last: Smith

4. DATE OF DEATH: Month: 9 — Day: 7 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 4 1898

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (County & State, or foreign country): Balto.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christopher Columbus Smith

14. MOTHER'S MAIDEN NAME: Mary Mullinnix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 217-03-1768

17. INFORMANT: Mrs. Emma B. Smith — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH
444X
DUE TO
(b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from 12/16/66, 19___, to 8/9/67, 19___, that (I) (☒) last saw the deceased alive on 8/9/67, 19___, and that death occurred at ___M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/11/67

22c. PHYSICIAN'S NAME (Type): Samuel Rubin, M.D.

22d. ADDRESS: 203 E. Patapsco Avenue, Baltimore, Md. 21225

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 9-11-67

23c. NAME OF CEMETERY OR CREMATORY: Balto. Mem.

23d. LOCATION (City or Town) (County) (State): Balto Md.

24. FUNERAL DIRECTOR: Lowry Byers — ADDRESS: 8728 Pulaski Hwy. Rosedale Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11901 — 11916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Baltimore
   c. LENGTH OF STAY IN 1b: 4yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: P.G.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
   d. STREET ADDRESS: 2700 Felter Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Lula V. — Middle — Last: Smith

4. **DATE OF DEATH**: Month: Sept. — Day: 14 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/5/'82

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Loundon Co., Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alphus Poland

14. MOTHER'S MAIDEN NAME: Mabel L. Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-56-1886

17. **INFORMANT**: Margaret Waataja 2700 Felter La. — Address: Bowie, Md.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cerebral failure — INTERVAL BETWEEN ONSET AND DEATH: ?
   DUE TO (b): Sclerotic Cardio Vascular Renal
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

   19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 1963, 19__, to 8/14, 19 67, that (I) (we) last saw the deceased alive on 9/13 19 67, and that death occurred at 3 a.M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/14/67

22c. PHYSICIAN'S NAME (Type): Alphus Poland

22d. ADDRESS: 11130 Leeds Rd. Odenton

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 16-67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: Simmons Bros. — ADDRESS: Simmons Bros.-1661-Good Hope Rd SE Wash DC

25a. REC'D BY REGISTRAR DATE: SEP 18 1967

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11902 — 11917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 105 Dorchester Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: Clarence — Last: Snider

4. DATE OF DEATH: Month: Sept. — Day: 1 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 June 1905

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. RR

11. BIRTHPLACE (County & State, or foreign country): Fairmont, W. Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Mabel Snider, Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 minute

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ASCVHD — 3 months

DUE TO (c): angina — 1 " "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mel.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/13/67, 19__, to 9/1/67, 19__, that (I) (we) last saw the deceased alive on 9/1/67 19__, and that death occurred at 11 A M, from the causes and on the date stated above.

22a. SIGNATURE: David Abramson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): David L. Abramson, M.D.

22d. ADDRESS: 707 Old Annapolis Road N.E., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5 Sept. 1967

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial

23d. LOCATION (City, town or county) (State): Elkridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11903 Items #8 & 11 Film #G392 9/20/67 ph 11918

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: ~~Anne Arundel~~ Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b: 12 hrs.	c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest tawn): Baltimore 03.2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital	d. STREET ADDRESS: 200 Birdwood Ave., — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: Thomas	Middle: Berville	Last: SNYDER	4. DATE OF DEATH	Month: September	Day: 9 — Year: 19 67
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Aug. 17, 1910	9. AGE (In years last birthday): 57 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer	10b. KIND OF BUSINESS OR INDUSTRY: Koppers Company	11. BIRTHPLACE (County & State, or foreign country): Hampstead, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Thomas F. Snyder		14. MOTHER'S MAIDEN NAME: Lotta B Frankforter ~~Lotta Frankforter~~	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 212-09-8866	17. INFORMANT — Address: Esther M. Snyder, same as 2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
331X
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) ~~saw the deceased~~ attended the deceased from Sept. 9, 19 67, to Sept. 9, 19 67 that (I) ~~saw~~ last saw the deceased alive on Sept. 9, 19 67, and that death occurred at 11:05 PM, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman, M.D. — ATTENDING PHYS. XXX MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9/11/67

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D. — 22d. ADDRESS: 16 Murray Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 13 Sept. 67	23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park	23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland	
24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md. 21061		25a. REC'D BY REGISTRAR DATE: SEP 14 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Jones	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11904

CERTIFICATE OF DEATH

17919

1. PLACE OF DEATH
a. COUNTY A.A. County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park 02-1
d. STREET ADDRESS Cypress Cir. Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Mildred Steins Dorfer

4. DATE OF DEATH Month Day Year: 9-3-67 19

5. SEX: F

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 Aug. 1905

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (County & State, or foreign country) Baltimore md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Engelke

14. MOTHER'S MAIDEN NAME: Estella Derr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-07-8735

17. INFORMANT Address: John F. Hergesheimer (Husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
410X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Mitral Stenosis + Mitral Insuff.
DUE TO (c) Rheumatic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to 9-3-67, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 11:30 AM, from the causes and on the date stated above.

22a. SIGNATURE Robert R. Hahn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 9-3-67.

22c. PHYSICIAN'S NAME (Type) Robert R. HAHN

22d. ADDRESS Severna Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 7 Sept. 1967

23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery

23d. LOCATION (City, town or county) (State) Woodlawn Md.

24. FUNERAL DIRECTOR ADDRESS: Langenfelder Funeral Home / Glen Burnie Md

25a. REC'D BY REGISTRAR DATE SEP 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11965

CERTIFICATE OF DEATH

11920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): North Arundel Convalescent Center

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
a. STATE: MARYLAND
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 1424 OAKDALE RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: LUCY Middle: Lost: STRAUSER
4. **DATE OF DEATH**: Month: 9 Doy: 21 Year: 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-27-15
9. AGE (In yeors lost birthdoy): 51 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10b. KIND OF BUSINESS OR INDUSTRY: Parking Garage
11. BIRTHPLACE (County & Stote, or foreign country): Houston Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Judson Knight
14. MOTHER'S MAIDEN NAME: Della (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 212-22-3431
17. INFORMANT Address: Mr. Raymond E. Strauser (Husband) Same As 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Congestive Heart Failure
DUE TO (b): Generalized arteriosclerosis
DUE TO (c): Carcinoma of breast
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 8/11, 1967 to 9/20, 1967, that (I) (we) last saw the deceased alive on 9/26 1967, and thot death occurred at 12 35 A M, from causes ond on the date stated above.

22o. SIGNATURE: Guillermo A. Livsao M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/21/67
22c. PHYSICIAN'S NAME (Type): Livsao
22d. ADDRESS:

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 24/67
23c. NAME OF CEMETERY OR CREMATORY: Tuscola Cemetery
23d. LOCATION (City or Town) (County) (Stote): Tuscola, Illinois

24. FUNERAL DIRECTOR: R K Singleton
ADDRESS: Singleton Funeral Home Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE SEP 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11905

CERTIFICATE OF DEATH

11921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
   c. LENGTH OF STAY IN 1b: 21 Months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maryland House of Correction

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 251 South Broadway Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: — Last: Substanley

4. **DATE OF DEATH**: Month: September — Day: 10 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-12-1912

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Philippi, W. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph (deceased)

14. MOTHER'S MAIDEN NAME: Catherine nee Kordea (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Denied

16. SOCIAL SECURITY NO.: 213-07-5856

17. INFORMANT: Institutional Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomin Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 7.

150X

DUE TO (b): to Generalized Metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on 9-10 19 67, and that death occurred at 10:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Rolando V. Goco, M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Rolando V. Goco, M.D.

22d. ADDRESS: 8th and Gorman Sts., Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-14-67

23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Walter Dabrowski — ADDRESS: 1005 Dundalk Avenue

25a. REC'D BY REGISTRAR DATE: SEP 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 5-63

Item 18 Film 393 10-23- MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G395 11/229/67 ph

11907

CERTIFICATE OF DEATH

13363

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 406 Morris Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Albert; Middle: ; Last: Swopes

4. DATE OF DEATH: Month: 9; Day: 25; Year: 1967

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/8/87

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): unknown

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Hospital Records, Crownsville Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Decubitus ulcers, gangrene early, of buttocks
DUE TO
(c):

455 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/15/ , 1967, to 9/25/ , 1967, that (I) (we) last saw the deceased alive an 9/25 19 67, and that death accurred at M, from causes and an the date stated above.

22a. SIGNATURE: Ludwig Benedict M.D. — ATTENDING PHYS. M.D. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/26/67

22c. PHYSICIAN'S NAME (Type): Ludwig Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: OCT 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: UNIVERSITY OF MD

23d. LOCATION (City or Town) (County) (State): BALTIMORE MD

24. FUNERAL DIRECTOR: Wm REESE III — ADDRESS: 101 N. WASHINGTON

25a. REC'D BY REGISTRAR DATE: OCT 11 1967

25b. REGISTRAR'S SIGNATURE:

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11908 Item #13 Film #G393 10/11/67 ph

CERTIFICATE OF DEATH

11922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital		d. STREET ADDRESS: 441 4th Street	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Baby	Girl	TEAT	September	24	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Negro	NEVER MARRIED ☒	September 24, 1967	— yrs.		15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ronald Jacho Jacobs	Evelyn Treat

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Clayton Treat 441 4th St

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity & Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Premature delivery

DUE TO (c):

776X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-24-67, 19___, to 9-24-67, 19___, that (I) (we) last saw the deceased alive on 9-24-67, and that death occurred at 9:15 P.M. from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. M.D. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
J. Allen				9-25-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A T ALLEN	62 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-29-1967	Pine Lawn	Annapolis Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William Reese #1 Annap. Md.	OCT 2 1967	Charles Yingling

7-26594

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11909

CERTIFICATE OF DEATH

11923

1. **PLACE OF DEATH**
   a. COUNTY: ANNE ARUNDAL (Anne Arundel) MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE, MD.
   c. LENGTH OF STAY IN 1b: 2 HOURS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: Anne Arunde[illegible]
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
   d. STREET ADDRESS: 5341 WASENA AVENUE 21225
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WALTER Middle D. Last TELECK

4. **DATE OF DEATH**: Month SEPT Day 4 Year 1967

5. SEX: MALE

6. COLOR OR RACE: CAUC

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 30 SEPT 1897

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET MSGT

10b. KIND OF BUSINESS OR INDUSTRY: ARMY

11. BIRTHPLACE (County & State, or foreign country): MAYFIELD, PA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DEMITRI TELECK

14. MOTHER'S MAIDEN NAME: EVA EWUACA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) 1917-1949

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: SAMUEL POLEN Address: 7 ALBERT MERTYLE. ROCKVILL[illegible] MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS
   DUE TO
   (b): Generalized Arteriosclerosis
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   INTERVAL BETWEEN ONSET AND DEATH: 5 HRS.
   332X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Part II af item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)

20f. (City ar tawn) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 4 SEPT, 1967, ta ____, 19__, that (I) (we) last saw the deceased alive an 4 SEPT 19 67, and that death accurred at 345P M, fram causes and an the date stated abave.

22a. SIGNATURE: Carl Rosen M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4 Sept 67

22c. PHYSICIAN'S NAME (Type): CARL ROSEN, CPT, MC

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/8/67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Fort Meyer, Virginia

24. FUNERAL DIRECTOR: McCully Funeral Home ADDRESS: 237 Potapsco Ave

25a. REC'D BY REGISTRAR DATE: SEP 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11910

CERTIFICATE OF DEATH

11924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02.1
   d. STREET ADDRESS: 630 Americana Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: — Last: TERRY

4. **DATE OF DEATH**: Month: September — Day: 25 — Year: 19 67

5. **SEX**: Female

6. **COLOR OR RACE**: White

7. **MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. **DATE OF BIRTH**: March 2, 1897

9. **AGE** (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. **KIND OF BUSINESS OR INDUSTRY**: DOMESTIC

11. **BIRTHPLACE** (County & State, or foreign country): New York

12. **CITIZEN OF WHAT COUNTRY?**: U. S.

13. **FATHER'S NAME**: UNKN

14. **MOTHER'S MAIDEN NAME**: CLARA E. DONNER

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): ND

16. **SOCIAL SECURITY NO.**:

17. **INFORMANT** — Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pump failure due to rupture of — INTERVAL BETWEEN ONSET AND DEATH: 15 min
DUE TO (b): myocardium due to acute anterior — 36 HRS
DUE TO (c): myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. **WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. **ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. **DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. **TIME OF INJURY** Month, Day, Year, Hour o.m. p.m. 19

20d. **INJURY OCCURRED** While at work ☐ Not While at work ☐

20e. **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 9-1, 1967, to 9-25, 1967, that (I) ~~(we)~~ last saw the deceased alive on 9-25 1967, and that death occurred at 12:40 P.M., from causes and on the date stated above.

22a. **SIGNATURE**: Pete F. Verkouw — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. **DATE SIGNED**: 9-26-67

22c. **PHYSICIAN'S NAME** (Type): Peter F. Verkouw M. D.

22d. **ADDRESS**: 1407 Forest Drive, Annapolis, Md.

23a. ~~BURIAL~~, ~~CREMATION~~, REMOVAL (~~Specify~~)

23b. **DATE THEREOF**: 9-26-67

23c. **NAME OF CEMETERY OR CREMATORY**:

23d. **LOCATION** (City or Town) BUFFALO (County) NY (State)

24. **FUNERAL DIRECTOR**: JOHN M. TAYLOR SONS — **ADDRESS**: ANNAPOLIS MD

25a. **REC'D BY REGISTRAR** DATE: OCT 2 1967

25b. **REGISTRAR'S SIGNATURE**: Charles Jones

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11911

CERTIFICATE OF DEATH

11925

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hosp. Glen Burnie, Md

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale, Glen Burnie, Md.
d. STREET ADDRESS: 12 Second Ave, So.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle C. Lost Thompson
4. DATE OF DEATH: Month Sept. Day 14 Year 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-18-87
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Arrow Brewery, Balto.
11. BIRTHPLACE (County & State, or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Thompsom
14. MOTHER'S MAIDEN NAME: Emma Weber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 214-01-9289-A
17. INFORMANT: Mrs. Dorothy E. Adams (Friend) Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septic shock
DUE TO (b): Gen'ly. Bacteremia + Septicemia
DUE TO (c): Urinary tract infection
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 609X
INTERVAL BETWEEN ONSET AND DEATH: 3 dys

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb, 1967, to 9-13, 1967, that (I) ~~(we)~~ last saw the deceased alive on 9-13 1967, and that death occurred at 9:15 PM, from causes and on the date stated above.

22a. SIGNATURE: Wayne B. Tate — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): WAYNE B. TATE
22d. ADDRESS: 108 Central Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): Burail
23b. DATE THEREOF: Sept. 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Richard V. Singleton
ADDRESS: Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE SEP 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11912 — 11926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 21 N. Glen Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ANDERSON — Last TONGUE, SR.

4. DATE OF DEATH: Month Sept. — Day 13 — Year 1967

5. SEX: male — 6. COLOR OR RACE: caus. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 27, 1919

9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): power station operator

10b. KIND OF BUSINESS OR INDUSTRY: public utilities

11. BIRTHPLACE (County & State, or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Tongue

14. MOTHER'S MAIDEN NAME: Addie Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): II

16. SOCIAL SECURITY NO.: 214-05-1337

17. INFORMANT — Address: Mrs. Thelma H. Tongue - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 2 YEARS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Oct, 1966, to 13 Sept, 1967, that (I) (we) last saw the deceased alive on 13 Sept 1967, and that death occurred at 6:54 M, from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edward S. Beck, MD

22d. ADDRESS: Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

23d. LOCATION (City, town or county) (State): Annapolis, Anne Arundel, Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Beverley E. Hopping — HOPPING FUNERAL HOME - Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 18 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11916 Items #3,8,9 23c & d Film #G393 10/2/67 ph 11927

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G. MEADE
c. LENGTH OF STAY IN 1b: 15 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
d. STREET ADDRESS: 13913 BRIARWOOD DRIVE
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARGARET Middle MILDRED Last VAIL (Veal)

4. DATE OF DEATH: Month SEPTEMBER Day 15 Year 19 67

5. SEX: F
6. COLOR OR RACE: CAU
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 5 SEPTEMBER 84 86
9. AGE (In years last birthday) 83 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (County & State, or foreign country): LACKAWANNA, SCRANTON, PA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MICHAEL SHEA
14. MOTHER'S MAIDEN NAME: MARY A. CORBETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A (If yes, give war or dates of service) N/A
16. SOCIAL SECURITY NO. 200-36-6652
17. INFORMANT: CHARLES VAIL(S) Address: Same as 2-D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SHOCK, ETIO. UNKNOWN — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
DUE TO (b):
DUE TO (c):
7829
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(his hospital)~~ attended the deceased from 0940 hrs 15 Sept 67 to 15 Sept 67, 19__, that (I) ~~(we)~~ last saw the deceased alive on 15 Sept 1967, and that death occurred at 0955 AM, from causes and on the date stated above.

22a. SIGNATURE: Lynn W. Holder — M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 15 September 67
22c. PHYSICIAN'S NAME (Type): LYNN W. HOLDER, CPT, MC
22d. ADDRESS: KIMBROUGH AH FT GEO G. MEADE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: SEPT 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery
23d. LOCATION (City or Town) (County) (State): Scranton Lacka Penna
24. FUNERAL DIRECTOR: Robert Walters ADDRESS: 538 W. 25th St. Bltd.
Laurel Funeral Home - Laurel, Md.
25a. REC'D BY REGISTRAR DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11914 — 11928

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWATER
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MIDLAND RD.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWATER
d. STREET ADDRESS: MIDLAND RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MILAS — Middle: RICHARD — Last: WALLACE
4. DATE OF DEATH: Month: 9 — Day: 25 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-16-1925
9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FLOOR SANDER
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: RICHARD D. WALLACE
14. MOTHER'S MAIDEN NAME: ONIE DAGLEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: ONIE D. WALLACE — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis Complicated — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: E. Linhart M.D. — M.O.
EXAMINER'S NAME (Type): E. LINHART M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 9-27-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 9-28-67 — 23c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN — 23d. LOCATION (City or Town) (County) (State): GLEN BURNIE MD.
24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR: OCT 2 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11915

CERTIFICATE OF DEATH

11929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rudolph — Middle: — Lost: Walters

4. DATE OF DEATH: Month: 9 — Day: 18 — Year: 1967

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/8/86

9. AGE (In years lost birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & Stote, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jeff Walters

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes give wor or dotes of service): unknown

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Address: Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
491X
DUE TO
(b):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome due to Cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from 5/18/1961, to 9/18/1967, that ~~(I)~~ (we) last saw the deceased alive on 9/18/1967, and that death occurred at 11:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/18/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 10.5.67

23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

23d. LOCATION (City or Town) (County) (Stote): Baltimore, Md.

24. FUNERAL DIRECTOR: Wm Reese II — ADDRESS: 108 W. Washington St — 10-5-67

25a. RECD BY REGISTRAR DATE: OCT 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11918

CERTIFICATE OF DEATH

11930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: AA Co — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7926 East End Dr

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: AA Co
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena 021
   d. STREET ADDRESS: 7926 East End Dr
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: E — Last: Watkins

4. DATE OF DEATH: Month: Sept — Day: 28 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb 21, 1887

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Baker

14. MOTHER'S MAIDEN NAME: Frances

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 10 days

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): arteriosclerotic cardiovascular disease — 2 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 15, 1949 to September, 1967, that (I) (~~we~~) last saw the deceased alive on Sept. 21 1967, and that death occurred at 6:2 M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/28/67

22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin

22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md. 21122

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/30/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

23d. LOCATION (City, town or county) (State): AA CO Md

24. FUNERAL DIRECTOR: McCully F.H. — ADDRESS: 737 Patapsco ave 21225

25a. REC'D BY REGISTRAR DATE: SEP 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Jorge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11917 Item 2 Film G393 9/29/67 KK

CERTIFICATE OF DEATH

11931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 9 months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Annapolis
   d. STREET ADDRESS: 74 College Creek Terrace Plaza Manor Nursing Home
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: NMN — Last: Wells

4. DATE OF DEATH: Month: Sept; Day: 16; Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 13-1877

9. AGE (In years last birthday): 90 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (County & State, or foreign country): A,A.Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson Wells

14. MOTHER'S MAIDEN NAME: Patricia Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Samuel Wells - 64 College Crk Terrace Anna. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudd Hrs
DUE TO (b)	Arteriosclerotic Cardiovascular Disease	Unknown
DUE TO (c)	Senility	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-21-, 1967, to 9-16, 19 67, that (I) (we) last saw the deceased alive on 9-16 1967, and that death occurred at 5:44 M, from the causes end on the date stated above.

22a. SIGNATURE: Richard H. Hunt M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt

22d. ADDRESS: 100 Chesapeake Blvd Glen Burnie Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 19-67

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III — ADDRESS: C.E.Hicks III Annapolis, Md.

25a. REC'D BY REGISTRAR DATE SEP 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR AIS (4) 20M S-63

4/3/67 10/18/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11918

CERTIFICATE OF DEATH

11932

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Convalescent Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1520 Byrd St 21230
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

30.4

3. NAME OF DECEASED (Type or print): First Gertrude Middle Marie Last Wetters
4. DATE OF DEATH: Month 9 Day 3 Year 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/20/1896
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Sudbrook
14. MOTHER'S MAIDEN NAME: Rosezella Adams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Harry V. Wetters — Address: 1653 Langford Rd 21207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): C V A
DUE TO (b): arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): AS (HT)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 5, 1967, to Sep 3, 1967, that (I) (we) last saw the deceased alive on Sep 2 1967, and that death occurred at 11:45 AM, from causes and on the date stated above.

22a. SIGNATURE: J. B. Ramirez MD
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.
22b. DATE SIGNED: 9/4/67
22c. PHYSICIAN'S NAME (Type): J. B. RAMIREZ MD
22d. ADDRESS: 3921 ANNAPOLIS RD Balto 27 / 1672 NORTHBOURNE RD Balto 12

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/6/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City or Town) (County) (State): A.A. Co. Md.
24. FUNERAL DIRECTOR: McCulley Funeral Home
ADDRESS: 30 E Fort Ave
25a. REC'D BY REGISTRAR DATE: SEP 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11918 — 11933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 245A Poplar Ridge Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: 245A Poplar Ridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VERNON — Middle EDWARD — Last WHITE

4. DATE OF DEATH: Month September — Day 8 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 11, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Davison Chemical

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Albert White

14. MOTHER'S MAIDEN NAME: Emma Travers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — 1942-1946

16. SOCIAL SECURITY NO.: 215-24-7857

17. INFORMANT Address: Mrs. Charles Anderson-191 Meadow Rd., Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	24 hours
DUE TO (b)	Coronary arteriosclerotic heart disease	6 months
DUE TO (c)	Essential hypertension	1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 10, 19 67, to Sept. 8, 19 67, that (I) (we) last saw the deceased alive on Sept. 6 19 67, and that death occurred at 1A M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/67

22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin, M.D.

22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md. 21122

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Ritchie Hgwy., A.A.Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce-4001 Ritchie Hgwy., Baltimore

25a. REC'D BY REGISTRAR DATE: SEP 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11920 — 11934

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): M Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: M Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS: Box 188 Rt. #1 Elvaton Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ELLEN — Last: WOOD

4. DATE OF DEATH: Month: Sept. — Day: 10 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 25,1879

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard Martin

14. MOTHER'S MAIDEN NAME: Mary Anne Dallas Gaither

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): O
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 219-54-3243

17. INFORMANT: (daughter) Address: Box 278 Mrs. Buelah Manthe, Elvaton Road Millersville

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Mar. 1951, to Aug. 9, 1967 that (I) (~~we~~) last saw the deceased alive on Aug. 9 19 67, and that death occurred at 11A, from the causes and on the date stated above.

22a. SIGNATURE: Samuel Rubin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/11/67

22c. PHYSICIAN'S NAME (Type): Samuel Rubin, M.D.
22d. ADDRESS: 203 E. Patapsco Avenue Baltimore, Md. 21225

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept.13,/67
23c. NAME OF CEMETERY OR CREMATORY: Wood's Family Cemetery
23d. LOCATION (City, town or county) (State): Millersville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Eugene B. Fleming
ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt exists as to the cause of death, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11921

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11935

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D.O.A. A.A. General Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: A.A.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02,1
   d. STREET ADDRESS: 1968 Rest St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Flovine — Middle: C. — Last: Wright

4. **DATE OF DEATH**: Month: 9 — Day: 3 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-19-1925

9. AGE (In years last birthday): 41 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dish Washer

10b. KIND OF BUSINESS OR INDUSTRY: Feeds Drugs

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Wright

14. MOTHER'S MAIDEN NAME: Annie Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: 217-18-5054

17. INFORMANT: Irene Simms — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute dilatation of the heart
   DUE TO
   4344
   Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost.
   (b):
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Albert L. Anderson M.D.

EXAMINER'S NAME (Type): ALBERT L. ANDERSON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ 445 South gate Rd

22. DATE SIGNED: 9/3/67

Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/7/67

23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn

23d. LOCATION (City or Town) (County) (State): Best Gate A.A. Md.

24. FUNERAL DIRECTOR: William Reese, II — ADDRESS: Anna. Md.

25a. REC'D BY REGISTRAR DATE: SEP 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11936

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: //////
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston, Md.
d. STREET ADDRESS: 5200 47th avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WALTER — Middle: S. — Last: YOUNG

4. DATE OF DEATH: Month: September — Day: 9, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15, 1896

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy Yard

10b. KIND OF BUSINESS OR INDUSTRY: U S Government

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James Young

14. MOTHER'S MAIDEN NAME: Katherine Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 217 52 6020

17. INFORMANT: Viola M Johnson — Address: Hanover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, Right Lung — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Richard I. Hochman M.D.
EXAMINER'S NAME (Type): Richard I. Hochman, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 16 Murray Ave Annapolis, Md.
22. DATE SIGNED: 9/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept 13, 1967
23c. NAME OF CEMETERY OR CRYPTORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington Virginia.

24. FUNERAL DIRECTOR: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: SEP 14 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jones

VR A15ME (5)
6M 1/67